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VITAMIN STABILITY DURING CANNING

● For over twenty years, intensive studies have been made of the stabilities of the vitamins under various conditions and treatments. Data accumulated indicate that certain vitamins contained in foods may, under specific conditions, be sensitive to oxygen in the presence of heat, or to heat or oxygen alone (1).

Broad details concerning vitamin stabilities are now general knowledge. The basic principle of commercial canning, namely heat sterilization of foods in sealed containers, is also generally known. As a consequence, there has been a tendency in some quarters to regard canned foods as deficient in certain, if not all, vitamins originally present in the raw material because of the conditions to which they were subjected during the canning procedures. Such a concept is not consistent with the established facts.

In future issues it is our intention to review the vitamin values of specific canned foods, as well as other nutritional virtues which they may possess. At this time we should like briefly to survey the matter of the stability of the most widely distributed vitamins during the canning procedure:

In general, vitamin A is not affected by commercial canning. This also appears true of vitamin G, as judged by present bio-assay methods for this complex dietary factor.

The stability of vitamin B_1 is dependent not only upon the heat treatment accorded it, but also upon the natural acidity of the food in which it is contained. In the more acid foods there is practically no loss of the vitamin during canning: in the less acid foods, which require longer and higher sterilization times and temperatures, the degree of retention is not as high.

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A fuller discussion of vitamin stabilities during canning procedures is not possible here. For further reading a recent publication dealing more in detail with this important subject is recommended (2).

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(1) The Vitamins, Sherman and Smith, The Chemical Catalog Co., New York, 1931. The Vitamins; Browning, Bailliere, Tindall and Cox, London, 1931. Vitamins, A Survey of Present Knowledge, Medical Research Council, H. M. Stationery Office, London, 1932.

(2) Ind. Eng. Chem. 24, 650 (1932)

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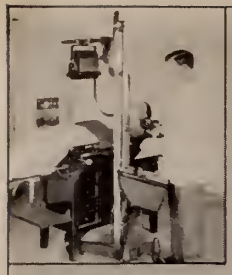
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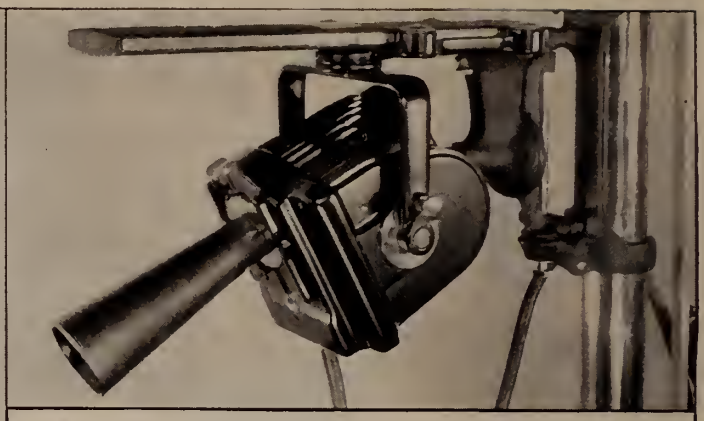
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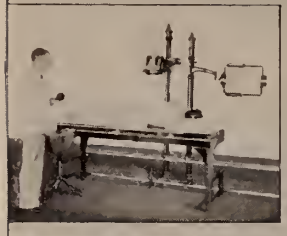






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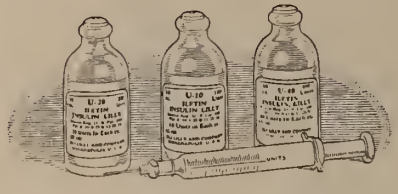
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FRIEDMAN TEST FOR PREGNANCY*

Report of 213 Cases

Herbert R. Mills, M.D.,
Tampa.

Since Aschheim and Zondek reported in 1927, their hormone test for pregnancy, using white mice, several modifications of the original test have been developed, as well as other tests for pregnancy, both biological and chemical. Of these tests, including the hormone tests, the Friedman modification using the rabbit appears to have been most generally accepted, and to have yielded the most satisfactory and accurate results. In fact in this country it seems to have largely supplanted the original Aschheim-Zondek test.

Briefly reviewing the principle of the Friedman reaction: it is based on the presence, in the urine of pregnant women, of large amounts of an anterior pituitary-like substance (probably produced by the placenta), which when injected into a mature female rabbit converts the mature graafian follicles into corpora hemorrhagica with luteinization. To use the words of King, this substance is elaborated "with explosive suddenness shortly after fecundation," and appears in the urine in excessive amounts (3000 to 5000 times normal).

The rabbit has so far proved to be the most suitable animal for the hormone test for pregnancy, not only because of its larger size and the ease with which it can be injected intravenously, but also because of the fact that it does not ovulate periodically as most mammals do. It can be used at any age after maturity, as its graafian follicles do not rupture or luteinize except after copulation. Also the ovaries are larger and the reaction in them can in most cases be easily determined macroscopically.

During the past three years, in the Laboratory of Clinical Pathology, we have made 238 Friedman tests, the detailed analysis of 213 of which is reported herewith. This analysis is based on the following questionnaire which was sent to every physician for whom we had made a test.

1. Age of patient;
2. Did patient prove to be clinically pregnant?
3. If pregnant (a) Uterine or ectopic gestation?
   (b) Approximate duration at time of test?
   (c) Number of days since last menstrual period, at time of test?
   (d) Final outcome of pregnancy (please underscore)
      1. Abortion
      2. Miscarriage
      3. Normal full term
4. If not pregnant, what was final clinical diagnosis?

Out of 238 copies of this questionnaire sent out, we received 213 replies.

The purpose of this report is to show the usefulness of the test in the determination of early pregnancy and its complications, in the differential diagnosis of other pathological conditions, and finally to show, by our mistakes, how the test may be conducted with the greatest degree of accuracy.

Of the 213 tests reported Table I tabulates the analysis of those cases which proved clinically to be non-pregnant. Of these 101 non-pregnant cases we obtained 100 negative reactions and one positive. From this table it is evident that the test was accurate in 99% of the non-pregnant cases. Let us analyze the case No. M282, on which we obtained the false positive reaction. This case was of a woman 42 years of age, complaining of amenorrhea. On account of this history, because of a slight opacity in the hemorrhagic follicles in the rabbit used in making the test, and also because the animal had been used four weeks previously with a positive result, I advised a repeat with a rabbit that had never before been used for the Friedman test. The second result, as Table I shows, was negative, which later proved to be clinically correct.

*Read before the Sixty-second Annual Meeting of the Florida Medical Association, Ocala, May 13-15, 1935.

According to the earlier literature, and with occasional exceptions in the current literature, the repeated use of laparotomized rabbits is recommended even in positive cases after three to four weeks, since the corpora hemorrhagica normally disappear in less than a week. This case, however, demonstrates the fact that in exceptional cases the corpora hemorrhagica may persist for thirty days or longer, and that it is unsafe to again use a positive animal for the Friedman test. It is not at all improbable that some at least of the occasional false positive results reported in the literature, and which have been attributed to other pathological conditions, were due to this error. Since we have discontinued using positive animals in our work, we have obtained no more false positive results.

Table II includes those cases which proved clinically to be pregnant, and to be suffering from a viable uterine gestation. Of 105 cases in this table 99 were positive, or 94.28%; four cases were falsely negative and two cases were doubtful. Let us analyze those cases in which the test resulted falsely, and also some of the correct cases which are especially instructive. Case No. J336 was a woman of twenty-eight years. The test was performed in accordance with our regular routine at that time, and resulted in a negative reaction. Seventeen days later the patient passed an entire ovum containing an embryo 9 mm. in length. An embryo of this size must have been less than one month of age, probably about three weeks. Consequently the patient was probably not more than four days pregnant at the time of the test, which is too early to expect a positive reaction. The test does not uniformly yield positive results when the patient is less than two weeks pregnant, although King reports a positive reaction ten days after a known coitus.

K135 is a similar case in that the patient was said by her physician to have been less than one week pregnant at the time of the test.

Case N215 is illustrative of the fact that a diagnosis can not always be made, even with the Friedman test, by the macroscopical method alone. This case was that of a woman, twenty-two years old, unmarried, complaining of symptoms referrable to the thyroid, anemia, cessation of menses, and finally an abdominal enlargement. The first specimen of urine was a first morning voiding, but of low concentration (about 1004). The rabbit's ovaries showed large clear vesicles, a few of which contained small specks of red blood, not at all typical of a positive reaction. Without recourse to microscopical sections a doubtful result would have necessarily been rendered. The microscopical sections, however, showed definite luteinization of a few follicles, and a positive report was given. The patient denied the possibility of pregnancy, and the test was repeated on a concentrated specimen of urine. The patient was instructed to restrict her fluid intake after supper preceeding the test, to void her urine on retiring, and again submit a first morning voiding. This time the test was macroscopically and microscopically positive. The patient still denied the possibility of pregnancy, but an x-ray examination supported the Friedman test.

Case K229 was negative on the first examination, but was repeated when it was learned that the specimen examined was not a first morning voiding. The second result using a first morning voiding of 1012 gravity was doubtful, and no microscopical examination was done. On account of the clinical evidence of uterine fibroma a laparotomy was done, and the uterus removed because of a large fibroid tumor located in the lower segment and obstructing the cervical canal. The fundus contained a living foetus of about four and a half months. In the light of our later experience, I am now convinced that the second test would have been definitely positive if the rabbit's ovaries had been examined microscopically. Also this second test might have been definitely positive macroscopically if the urine had been more concentrated by restricting the patient's fluids.

Case J923 was a woman of about forty years who had passed her regular menstrual period about two weeks. At this time we were still examining our rabbits by laparotomy and in this case the ovaries showed no hemorrhagic follicles. Because of the congestion of the uterus, however, I was not satisfied with a negative report and requested a repeat, as it occurred to me that in searching for the ovaries through the laparotomy incision, it might be possible to rupture a single hemorrhagic follicle. In fact this idea was supported by the presence of a minute amount of free blood in the region of one of the ovaries. The repeated test as shown by Table II, was positive. This experience confirms the idea that I have long entertained in examining rabbits by laparotomy, that the hemorrhagic follicles may easily be ruptured through a small incision. For

this reason, and also because of the fact already discussed that a positive rabbit is no longer suitable for repetition work, it is best from the standpoint of accuracy to kill the rabbits and examine the ovaries without handling through a wide incision.

I wish to call special attention to case N195, in which it may be noted under complications that the patient was suffering from large bilateral serious cystadenomata of ovaries, one of which measured 16 by 14 cm., and the other 14 by 10 by 6 cm. It seems remarkable that a patient could become pregnant with ovaries so altered by disease. On gross examination one of the tubes appeared to be functioning.

Case N843 is worthy of special mention, as this patient had only passed three days beyond her usual menstrual period at the time of the test, and is the earliest case in our series upon whom we obtained a positive reaction.

Case 3397 is an unexplained error.

In Table III appear those cases which are not included in Table I and II. Cases L8, N303, J967, and 025 were all negative, but subsequent histories showed that the foetuses were dead at the time of the tests. One of these (case L8) was an ectopic gestation. In cases of death of foetus, a positive reaction may be expected as long as the placenta is alive, or in biological contact with the uterus, and in many cases until about a week thereafter, when the test will be negative. Case No. 519 illustrates this point, and also emphasizes the use of the test in determining the presence of retained placental tissue, or its derivatives. This patient was not suspected of being pregnant, but in the course of a laparotomy it was discovered that the uterus was of the size and appearance of about a six weeks pregnancy. The operation was terminated, and the urine examined by the Friedman test showed a positive reaction. About a week later the patient passed a few grams of necrotic appearing tissue associated with blood and fibrin. Microscopical examination showed a chorion-epithelioma of the syncytioma type, and a curettage was recommended. A few days later we received the uterine curettings from this patient and confirmed the report of syncytioma and advised another Friedman test in about a month or two in order to determine if the disease had been completely eradicated. We have not yet received this follow-up specimen, but the test should be repeated in cases of this kind as a positive result would be an indication for further operative interference.

Case No. L472 proved clinically to be a ruptured ectopic pregnancy. This diagnosis, however, was not confirmed by tissue examination, and we are unable to say whether the foetus was dead at the time of the test.

Case 0882 was a suspected teratoma of the testicle, on whom the Friedman test was negative. The negative result was later confirmed by the tissue report of chronic epididymitis.

Friedman obtained 81.6% positive cases in ectopic pregnancies. The failure of ectopic pregnancies to give positive reactions in a high percentage of cases is said to be due to loss of contact and death of chorionic tissue. According to King a positive reaction in ectopic pregnancy indicates that live chorionic tissue has been in existence in the last week.

The technique which we have adopted in the conduct of the Friedman test is as follows:

Isolate a female rabbit of about three and a half pounds for thirty days. Inject intravenously fifteen cubic centimeters of the patient's urine. Repeat injection in twenty-four hours with the same urine, and kill the rabbit forty-eight hours after the first injection. The urine should be a concentrated first morning specimen obtained after the restriction of fluids on the evening preceeding the test. The patient should also be instructed to void her urine on retiring. The urine should be kept in a refrigerator from the time of voiding until submitted to the pathologist. The patient should avoid chemical contamination such as lysol or other disinfecting and cleansing material in the bed pan or container in which the urine is collected. It is preferable to withdraw medication from the patient preceding the test, especially such drugs as the opiates, barbiturates, etc. By carefully observing these points with reference to refrigerating the specimen, avoiding chemical contamination or preservatives and medication, very little difficulty should be experienced in the loss of animals incidental to the test.

In connection with the Friedman test, we have recently employed the pupillary test of Bercovitz, according to the modification of Davis, Konikov and Walker, but found the reaction to be variable and uncertain for even presumptive diagnostic purposes.

TABLE I—NON-PREGNANT CASES

Case. No.	*Age*	*Diagnosis*	*Remarks*	*Result of Hormone Test*
M282	42	Clinically non-pregnant—amenorrhea	Rabbit used for test had been used before with positive results	Positive
M282	42	Clinically non-pregnant—amenorrhea	Test repeated with unused rabbit	Negative
L51	42	Menopause—missed one menstruation	42 days since last menstrual period	Negative
1929	50	Clinically non-pregnant		Negative
N672	41	Clinically non-pregnant	8 weeks since last menstrual period	Negative
H706	46	Menopause		Negative
J968	44	Menopause		Negative
J968	44	Menopause		Negative
1161	42	Menopause		Negative
667	42	Clinically non-pregnant—accident followed by suppressed menses		Negative
N312	44	Clinically non-pregnant	40 to 50 days since last menstrual period	Negative
N742	51	Menopause—fear of pregnancy	64 days since last menstrual period	Negative
N127	45	Clinically non-pregnant—irregular menses		Negative
0566	40	Beginning menopause	2 months since last menstrual period	Negative
0120	53	Menopause	Missed 2 or 3 periods	Negative
C712	43	Menopause	Missed one period	Negative
D445	..	Menopause		Negative
N988	40	Clinically non-pregnant—neurosis	1 month since last period	Negative
M731	40	Beginning menopause	One or two months since last menstrual period	Negative
0529	38	Menopause	6 months since last menstrual period	Negative
0743	51	Menopause	3 months since last menstrual period	Negative
0853	43	Menopause	Missed 2 menstrual periods	Negative
0358	39	Menopause		Negative
H832	..	Myofibromata; pseudomucinous cystadenoma of ovary; obliterative fibrosis of appendix		Negative
J634	..	Dermoid cyst of ovary		Negative
J658	..	Ovarian cysts (lutein)		Negative
K43	24	Ovarian cysts		Negative
K268	39	Myofibroma of uterus		Negative
M115	..	Endometrial cyst of ovary (Sampson's cyst)		Negative
M517	21	Chronic pelvic inflammatory disease, secondary to syphilis	Doctor feared an ectopic	Negative
H574	..	Acute pus tubes		Negative
J924	..	Myofibroma of uterus		Negative
J110	..	Multiple benign myofibromata of uterus		Negative
L862	46	Carcinoma of stomach		Negative
0103	..	Myofibroma of uterus		Negative
B437	30	Clinically non-pregnant—unexplainable hemorrhage, tissue report; blood and fibrin		Negative
I561	35	Clinically non-pregnant—menstruation irregular	8 weeks since last menstrual period	Negative
020	22	Clinically non-pregnant—delayed menstruation; menstruation started 3 days after test	36 days since last menstrual period	Negative
I594	33	Clinically non-pregnant—suppressed menstruation following serious accident	60 days since last menstrual period	Negative
N556	32	Clinically non-pregnant "suppressed menses"	3 weeks since last menstrual period	Negative
L605	25	Clinically non-pregnant "suppressed menses"		Negative
L806	20	Clinically non-pregnant—missed periods		Negative
H263	..	Clinically non-pregnant—"suppressed menses"	Missed several menstrual periods	Negative
G820	..	Clinically non-pregnant—menstruated normally 2 days after test		Negative
H208	..	Clinically non-pregnant—menstruated normally soon after test		Negative
J335	..	Clinically non-pregnant—menstruated normally soon after test		Negative
F163	35	Clinically non-pregnant—menstruated normally 24 hours after test		Negative
J445	..	Clinically non-pregnant—menstruated normally 4 days after test		Negative

TABLE I—NON-PREGNANT CASES—Continued

TABLE 1—NON-PREGNANT CASES—Continued

Case No.	Age	Diagnosis	Remarks	Result of Hormone Test
0443	42	Clinically non-pregnant—mental shock from grief	6 weeks since last menstrual period	Negative
M301	30	Clinically non-pregnant—amenorrhea and dysmenorrhea for 1 year		Negative
J111	..	Clinically non-pregnant	Missed one menstrual period	Negative
I507	38	Clinically non-pregnant	Missed one menstrual period	Negative
L196	..	Clinically non-pregnant	Missed one menstrual period	Negative
K758	..	Clinically non-pregnant—suppressed menses		Negative
J540	35	Clinically non-pregnant—dipsomaniac	Few months since last menstrual period	Negative
I740	..	Clinically non-pregnant—irregular menses		Negative
0444	32	Clinically non-pregnant—thyroid dysfunction	6 months since last menstrual period	Negative
M188	..	Clinically non-pregnant—attempted black mail		Negative
J879	26	Clinically non-pregnant—guilty conscience		Negative
K724	49	Clinically non-pregnant—guilty conscience		Negative
K624	29	Clinically non-pregnant—over anxious		Negative
J925	42	Clinically non-pregnant—diagnosis "anemia"	50 days since last menstrual period	Negative
I136	..	Clinically non-pregnant		Negative
I665	..	Clinically non-pregnant		Negative
M75	..	Clinically non-pregnant		Negative
N3	..	Clinically non-pregnant		Negative
N3	..	Clinically non-pregnant		Negative
M756	..	Clinically non-pregnant		Negative
M238	..	Clinically non-pregnant		Negative
M285	..	Clinically non-pregnant		Negative
N491	..	Clinically non-pregnant		Negative
H23	32	Clinically non-pregnant—irregular menses		Negative
H23	32	Clinically non-pregnant—irregular menses		Negative
L374	..	Clinically non-pregnant		Negative
L169	..	Clinically non-pregnant		Negative
I149	..	Clinically non-pregnant		Negative
J4	..	Clinically non-pregnant		Negative
J4	..	Clinically non-pregnant		Negative
J825	..	Clinically non-pregnant		Negative
J657	..	Clinically non-pregnant		Negative
I868	..	Clinically non-pregnant		Negative
M147	..	Clinically non-pregnant		Negative
M958	..	Clinically non-pregnant		Negative
N236	..	Clinically non-pregnant		Negative
021	..	Clinically non-pregnant		Negative
L990	32	Clinically non-pregnant		Negative
N169	..	Clinically non-pregnant		Negative
K564	..	Clinically non-pregnant		Negative
K564	..	Clinically non-pregnant		Negative
N503	..	Clinically non-pregnant		Negative
N740	..	Clinically non-pregnant		Negative
L449	..	Clinically non-pregnant		Negative
J869	24	Clinically non-pregnant	50 days since last menstrual period	Negative
3144	..	Clinically non-pregnant—menorrhagia		Negative
17	35	Clinically non-pregnant		Negative
N833	..	Clinically non-pregnant		Negative
0441	..	Clinically non-pregnant		Negative
L76	..	Clinically non-pregnant		Negative
L381	..	Clinically non-pregnant		Negative
0738	24	Clinically non-pregnant		Negative
M619	30	Cystic ovary		Negative

TABLE II—PREGNANT CASES

Case No.	Gestation			Duration	No. Days since Last Mens. Period	Abortion	Miscarriage	Full Term	Remarks	Result of Hormone Test
	Age	Uterine	Ectopic							
J336	28	Yes	....	4 days when spec. recd...	.....	.....	Passed foetus 9 mm. long	.....	.....	Negative
K135	..	Yes	....	Less than 1 week.....	.....	.....	.....	Yes	.....	Negative
N215	22	Yes	....	5 months	.....	.....	.....	.....	X-ray proved positive.....	Positive
N215	22	Yes	....	5 months	.....	.....	.....	.....	X-ray proved positive.....	Positive
K229	..	Yes	....	4 months	.....	.....	.....	.....	*	Negative
K229	..	Yes	....	4.5 months	.....	.....	.....	.....	*	Doubtful
J923	..	Yes	....	1 month	14 days	.....	.....	.....	**	Doubtful
J923	..	Yes	....	1 month	14 days	.....	.....	.....	**	Positive
N195	..	Yes	....	6 weeks	.....	.....	.....	.....	***	Positive
N843	28	Yes	....	3 weeks	3 days	Therapeutic	.....	.....	.....	Positive
3397	32	Yes	....	Mens. for 23 days, up to day of test.....	.....	.....	.....	Yes	.....	Negative
L491	23	Yes	....	.....	44 days	Yes	.....	.....	.....	Positive
M765	26	Yes	....	2 months	60 days	Therapeutic	.....	.....	Pulmonary tuberculosis.....	Positive
N623	..	Yes	....	.....	.....	.....	.....	.....	.....	Positive
L450	30	Yes	....	2 months	45 days	Therapeutic	.....	.....	Hypothyroidism....	Positive
I601	39	Yes	....	5 weeks	30 days	Yes	.....	.....	.....	Positive
N557	26	Yes	....	6 weeks	38 days	Yes	.....	.....	.....	Positive
K446	17	Yes	....	3 months	.....	.....	.....	Yes	.....	Positive
N620	..	Yes	....	7 weeks	21 days	.....	.....	Yes	.....	Positive
M78	26	Yes	....	6 weeks	14 days	Yes	.....	.....	.....	Positive
203	29	Yes	....	7 weeks	21 days	Yes	.....	.....	.....	Positive
N746	25	Yes	....	4 months	.....	.....	.....	.....	.....	Positive
L492	35	Yes	....	2 months	.....	Yes	.....	.....	.....	Positive
033	38	Yes	....	2 months	42 days	Yes	.....	.....	.....	Positive
M785	29	Yes	....	4 months	.....	.....	Dead foetus	.....	Severe hemorrhage 3 wks. before test.	Positive
0344	..	Yes	....	.....	.....	.....	.....	.....	.....	Positive
0344	..	Yes	....	.....	.....	.....	.....	.....	.....	Positive
N251	19	Yes	....	.....	28 days	.....	Yes	.....	.....	Positive
G108	..	Yes	....	weeks	.....	Yes	.....	.....	.....	Positive
G115	..	Yes	....	.....	.....	Incomplete	.....	.....	.....	Positive
G109	..	Yes	....	.....	.....	.....	.....	.....	.....	Positive
G425	..	Yes	....	.....	.....	Yes	.....	.....	.....	Positive
G494	..	Yes	....	.....	.....	Yes	.....	.....	.....	Positive
0473	..	Yes	....	.....	.....	.....	.....	.....	.....	Positive
L595	..	Yes	....	.....	.....	Yes	.....	.....	.....	Doubtful positive
L595	..	Yes	....	.....	.....	Yes	.....	.....	.....	Positive
I985	32	Yes	....	.....	.....	.....	.....	Yes	.....	Positive
M815	41	Yes	....	3 months	7 days	.....	.....	Yes	.....	Positive
031	42	Yes	....	3 months	.....	.....	.....	.....	.....	Positive
0219	37	Yes	....	.....	.....	.....	.....	.....	.....	Positive
N662	..	Yes	....	.....	.....	.....	.....	.....	.....	Positive
6151	..	Yes	....	3.5 months	.....	.....	.....	.....	.....	Positive

TABLE II—PREGNANT CASES—Continued

Case No.	Gestation			Duration	No. Days since Last Mens. Period	Abortion	Miscarriage	Full Term	Remarks	Result of Hormone Test
	Age	Uterine	Ectopic							
8522	..	Yes	....			Yes				Positive
M98	28	Yes	....							Positive
K707	32	Yes	....	1 month				Yes		Positive
J219	..	Yes	....							Positive
I302	..	Yes	....			Yes				Positive
J3	..	Yes	....			Yes				Positive
G244	..	Yes	....					Yes		Positive
I125	..	Yes	....							Positive
G330	20	Yes	....							Positive
F615	20	Yes	....							Positive
J638	33	Yes	....	3 months		Therapeutic				Positive
4615	27	Yes	....	7 weeks		Criminal				Positive
L100	..	Yes	....							Positive
J313	..	Yes	....							Positive
0488	17	Yes	....			Yes				Positive
G790	..	Yes	....							Positive
N814	40	Yes	....	2 months						Positive
J784	..	Yes	....							Positive
0265	33	Yes	....							Positive
9068	35	Yes	....							Positive
9068	35	Yes	....							Positive
N725	..	Yes	....							Positive
N485	..	Yes	....							Positive
N166	22	Yes	....	2.5 months						Positive
L173	34	Yes	....	1.5 months				Yes		Positive
J405	35	Yes	....	4 weeks				Yes		Positive
H216	..	Yes	....			Yes				Positive
L322	21	Yes	....		60 days					Positive
L489	22	Yes	....	3 months				Yes		Positive
0451	..	Yes	....							Positive
K424	..	Yes	....							Positive
0134	20	Yes	....	5 months						Positive
M698	18	Yes	....	3 weeks		Yes				Positive
0491	26	Yes	....	3 months						Positive
G461	24	Yes	....	3 weeks				Yes		Positive
L330	..	Yes	....							Positive
0506	29	Yes	....	3 months		Yes				Positive
1937	33	Yes	....	.5 months	5 years			Premature living child		Positive
N662	29	Yes	....	2 months		Therapeutic				Positive
K633	..	Yes	....							Positive
M461	24	Yes	....			Yes				Positive
0745	29	Yes	....		30 days					Positive
J104	..	Yes	....							Positive
L609	30	Yes	....	2 months		Yes				Positive
M457	..	Yes	....							Positive
L747	33	Yes	....							Positive
L222	30	Yes	....	2 months						Positive

TABLE II—PREGNANT CASES—Continued

Case No.	Gestation			Duration	No. Days since Last Mens. Period	Abortion	Miscarriage	Full Term	Remarks	Result of Hormone Test
	Age	Uterine	Ectopic							
K956	..	Yes	....							Positive
I741	..	Yes	....							Positive
G424	..	Yes	....							Positive
N805	21	Yes	....		42 days	Criminal by widwife				Positive
8220	40	Yes	....		21 days					Positive
I876	30	Yes	....							Positive
I765	..	Yes	....							Positive
M878	..	Yes	....							Positive
I111	..	Yes	....	3 weeks						Positive
K263	33	Yes	....	1 month		Yes				Positive
J202	35	Yes	....	3 or 4 months				Yes		Positive
N411	..	Yes	....							Positive
0108	36	Yes	....		90 days					Positive
0516	34	Yes	....		38 days			Yes		Positive
0564	..	Yes	....							Positive
0564	..	Yes	....							Positive

* Tissue report Multiple benign myofibromata of uterus; pregnancy of 4.5 months; obliterative fibrosis of appendix.
** Tissue report: Retained placenta.
*** Tissue report: Bilateral serous cystadenomata; uterine gestation of 6 weeks.

TABLE III

Case No.	Gestation			Duration	No. Days since Last Mens. Period	Clinical Diagnosis	Result of Hormone Test
	Age	Uterine	Ectopic				
J967	..	Yes	....			"Death of placenta and foetus"	Negative
L8	..	....	Yes			"Death of placenta and foetus"	Negative
N303	..	Yes	....			Dead twins—placenta microscopically necrotic	Negative
025	..	Yes	....			Dead foetus and placenta	Negative
L472	24	....	Yes	2 weeks		Two weeks later had ruptured ectopic	Negative
519	28	Yes	....	13 days		Chorionepithelioma of syncytioma type	Positive
0882	..	....	....			Chronic epididymitis	Negative

SUMMARY

A total of 213 Friedman cases have been presented, of which 96.7% have been proven correct by subsequent clinical events. Our experience shows that a certain number of false positive results can be avoided by not using rabbits which have been used before with positive results. A certain number of false negative results can be avoided by not laparotomizing the rabbit, but by killing the animal and exposing the ovaries with wide dissection. A certain number of false negative reactions can be avoided also by obtaining a concentrated first morning voiding. If a test should prove negative in a patient who has passed a regular mentsrual period, only a day or so, it must be borne in mind that the patient may be less than two weeks pregnant, and the test should be repeated at a suitable interval. A certain number of errors can also be avoided by examining the ovaries of the rabbit by microscopical section.

The test has proven useful in our series in the diagnosis of early pregnancy, and differentially (Table I) in fifteen cases of menopause; seven ovarian cysts, including one dermoid cyst, one lutein cyst, one endometrial cyst or chocolate cyst, two psuedomucinous cystadenomata, and two cysts of unknown type; two cases of acute pus tubes; three myofibromata of uterus; and one case of chronic epididymitis (all of which were negative); also in suppressed, delayed and irregular menses; fear of pregnancy and one case of attempted blackmail. One case of chorionepithelioma was positive.

In closing I wish to emphasize that the Friedman test, like all other single diagnostic methods, should not be relied upon exclusively in the diagnosis of pregnancy or other conditions, but should be employed only in correlation with a careful physical examination and clinical history of the case.

DISCUSSION

Dr. L. Y. Dyrenforth, Jacksonville:

I have enjoyed Dr. Mills' paper very much. I am a pathologist at Jacksonville. In these pregnancy tests, our results and our figures coincide very closely with those that Dr. Mills has given you.

I was interested in two points that might not interest the other medical men. I should like to hear what Dr. Mills has to say about the technique of injecting a number of times in say, two or three hundred rabbits. I have made a few subcutaneous injections, using an extra rabbit for the purpose, and in each instance have succeeded in getting a positive test where the ear vein control was positive. I have never seen anything in the literature relative to making these subcutaneous injections and would like to ask Dr. Mills if, in his opinion, it would not be as effective as intravenous injection, provided the specimen is concentrated, thereby saving a good many rabbits that do not seem to survive intravenous injections.

This leads to the second question I would like to ask—as to the preparation of Dr. Mills' specimens. We detoxicate our specimens by shaking with ether, separately, and then allowing the excess to evaporate. It is my opinion that a lot of times shock is caused by getting this intravenous dose of 10 or 15 cc. of urine, and I know that I have killed as many as four rabbits in quick succession with the same urine before getting any results with that particular specimen.

Dr. Iva C. Youmans, Miami:

It was about the year 1925 that a woman came into our laboratory with a sample of urine and asked that an examination be made of this to determine whether or not she was pregnant. A contagious smile passed over the faces of several who were at work in the laboratory at the time and I am sure that we each had a feeling of pity for the ignorance of this patient who did not know that we could not diagnose pregnancy in that way.

This is quite in contrast to a woman who about a week ago came by to tell us that the negative test for pregnancy had been verified by the appearance of her near normal menstruation. This latter was the case of a woman who wants a child but in the case of a pregnancy she felt that for the best interest of the baby she must make some drastic changes in her immediate plans—she must not take the extended trip she had anticipated. It was too early for reliable pelvic diagnosis and yet it was important that she should know. As in the case of the first woman she had brought in a specimen of urine but with a very different response on the part of the laboratory.

This paper which we have listened to this morning brings to our attention one of the most outstanding advances in modern medicine. I am satisfied that none will deny this statement for who in the practice of medicine, and I might also say who in family life, has not time and again been face to face with the question as to

the existence of a pregnancy and often in a most serious way: the surgeon in his proposed abdominal operation; the internist in ruling out suggestive symptoms; the obstetrician and gynecologist ever in his work; the family in laying early plans for the new-comer; the mother who has nine months of her immediate future so closely interwoven with the new life for whose well-being she is responsible. So much have we desired and needed a test for the early diagnosis of pregnancy that much investigation has been made along this line and many tests have been offered with indifferent results. When the Abderhalden test was advanced about 1912 we had great hopes that this would fill a long-felt need, but for various reasons this has fallen short of our expectations as a practical routine test and we have slowly and unwillingly relinquished the thought of applying it as such.

The announcement of Aschheim and Zondek in 1927 of their practical test for early pregnancy was doubtless received with a bit of hesitation but time has told the tale and has placed this test on a firm basis—a test whose percentage of correct results ranks very high in comparison with the average run of laboratory tests.

Since the work of Aschheim and Zondek various modifications of the test for pregnancy based on the presence in the urine of certain hormones have been worked out. Of these I shall mention three:

1. A test which was reported a short time ago—the use of a fish, the Japanese female bitterling—excited interest as a very practical, economical test, easily performed and easily read. You probably are acquainted with the manner of this test in which a certain amount of the unknown urine is placed in a certain amount of water in the bowl in which is placed a standardized female bitterling. The lengthening of the ovipositor of the fish is the factor on which the positive diagnosis is based. One fish might be used over and over in these tests. It was rather discouraging, however, when a recent journal of the A. M. A. gives the results obtained by other investigators which seem to discredit the reliability of this test.

2. A few years ago at one of the national conventions one investigator reported the use of male guinea pigs in the diagnosis of pregnancy. I was unable to learn whether or not this paper was ever published and as so little has been found written about this test we have ceased to use it as a routine though in all cases in which we have used it the results have been wholly satisfactory.

3. My past experience has been largely with a modification of the Aschheim-Zondek test. In this, our laboratory routine consists in the use of immature female rats twenty-eight to thirty-five days old. One rat is injected with a negative control urine and two rats are injected with the unknown. One and one-half cc. of urine are injected subcutaneously three times a day for three days and at the end of one hundred hours from first injection the animals are autopsied. The appearance in the ovaries of hemorrhagic follicles constitutes a positive reaction. It is interesting to note, however, in addition to this that there is marked development in the size of the bi-cornuate uterus as well as that of the ovaries. In many cases the vagina that was inperforate at the beginning showed perforation at the end of the test. In my laboratory all cases in our series, which is not a long one, have proven correct with one exception. This was the case of a colored woman, and I am not sure that an early abortion was not a sequel in this case. Practically all of our cases have been controlled with two different procedures. Recently we have been using the Friedman test, and we prefer it. The modification which we have been using as mentioned above presents difficulties: first, obtaining rats of the right age; and again the laboratory workers do not enjoy giving the oft-repeated injections of relatively large amounts of urine to such small animals; the toxicity of the urine often kills the rat; the test requires 100 hours in contrast to the 24 hours of the Friedman test. We might mention a number of other tests and modifications most of which would present some undesirable features for a routine procedure. However, referring again to the Friedman test, a most helpful discussion of which has been presented to us this morning, I am convinced that this of all tests demonstrated up to the present time must be acceded the preference, when an early report on a suspected pregnancy is desired.

Some time ago Dr. Mills spoke to me of the gratifying results he had had with this test, so it is with keen added interest that I have learned of the results obtained in this long list of experiences with this procedure. I would place especial interest on his interpretations of his false results, and from these experiences I too expect to profit.

I thank Dr. Mills for this well-written paper

detailing a careful study of an excellent series of cases in a field of medicine in which we are all deeply interested irrespective of the *ology* in which we find ourselves classified. I am sure all who have heard the paper and all who will read it later fully concur with me in this expression of appreciation.

Dr. R. G. Nelson, Tampa:

I think that Dr. Mills is due to be commended for the valuable amount of work he has put on this paper and the meticulous way in which he has approached this subject. He has brought a real message to the Association. He has worked out the means and ways of perfecting the Aschheim-Zondek or the Friedman modification in such a way that he is now able to say to us that he can give us at least 98% perfect laboratory test. I know of no other test of this character from which you can expect such a high percentage of perfection. If the clinician will avail himself of this test he can certainly save himself many a pitfall.

It is also valuable in a medico-legal way. We all know and remember back in our interne and early practice days where we have operated with a diagnosis of fibroid, and to our chagrin found a pregnancy. It is very valuable in differentiating or helping you to diagnose your ectopic pregnancies. The various forms of chorionepitheliomas, hydatidiform mole, etc., are often confused with pregnancy, and it is here that I think this test is of the most value. I would like to ask Dr. Mills to discuss that in his rebuttal. It is my opinion that chorionic epitheliomas give you a very high percentage of positives.

I think the rendition is such that I want to again commend Dr. Mills, and recommend to the obstetrician, the gynecologist and the general practitioner that he further avail himself or this valuable laboratory test.

Dr. H. D. Smith, Sanford:

I would just like to offer this suggestion; pos- I am not a laboratory man. While in St. Louis is 1933 Dr. Brown of the Department of Gynecology and Obstetrics was using this test, but instead of urine he used blood serum. He has been very successful with this method and he gets an earlier reaction than he does with urine.

I would just like to offer this suggestion; possibly Dr. Mills might like to try it. He uses 2 cc. of blood serum instead of urine and his results are excellent. The test is otherwise the same. In 500 cases his results were almost positive throughout. Dr. Brown is a very efficient man, very capable and he has been very conscientious in working out this test from a blood serum standpoint, instead of urine.

I would like to know if any of you laboratory men here have tried this serum method. He gets much earlier reaction from the blood serum than from concentrated urine.

Dr. Herbert R. Mills, Tampa (concluding):

In regard to the use of blood serum: As Aschheim reported in his excellent paper in the American Medical Journal about two weeks ago, the hormone upon which his test is based is excreted in extremely large amounts in the urine, five thousand times in a case of normal pregnancy above that which is excreted in the urine in the absence of pregnancy. For that reason the urine has proven satisfactory for the test. Human blood is often very toxic to rabbits. I have had experience in giving rabbits injections of human blood for various purposes, and they do not tolerate it well. So for the reason that we find urine less toxic than human blood, strange as it may seem, we have not used blood serum in these tests.

Dr. Nelson has asked about chorionic epitheliomas of the various types including hydatidiform mole. The hormone upon which this test is based is excreted in extraordinarily large amounts in these conditions, in much higher amounts than in normal pregnancy. For that reason I believe it would be advisable, if we were to diagnose chorionic epitheliomas by this test, to use the quantitative method of Ferguson. The Friedman test is merely a qualitative test. I believe that if a negative reaction is obtained with the Friedman test it is safe to say that the patient does not have a chorionic epithelioma, or that your male patient does not have a teratoma of the testicle. In differentiating from normal pregnancy or in following the progress of these conditions, I believe that it would be necessary to test the urine quantitatively by Ferguson's method, using white mice.

Dr. Youmans mentions, and Dr. Nelson also, the various uses of the test. This was included in my paper. One thing, however, was omitted in the discussions, and that is the use of the test in teratoma of the testicle. As Ferguson says, a high percentage of positives is obtained in these

cases. I have had only one suspected case in which we obtained a negative result. This man had a testicular enlargement and because of the negative Friedman test a simple epididymectomy was done. A microscopical section showed it to be merely a case of chronic epididymitis.

Dr. Dyrenforth recommends giving the urine subcutaneously, and I infer that he does this to avoid the toxic effect of the urine used intravenously. He also mentioned purifying the urine. The reason I did not mention this is because we are very particular to get our urine specimens fresh. As stated in my summary, I recommend that the urine be kept in the refrigerator from the time that it is voided. And then by avoiding medication on the part of the patient we avoid any toxic effect on the rabbit from such sources. By using these precautions, we have very little trouble with rabbits dying.

I do not think as quick results would be obtained by the subcutaneous method as by the intravenous method. That was one objection to the original Aschheim-Zondek test. When white mice are injected intraperitoneally or subcutaneously the result does not show up as quickly. One advantage of the Friedman test is the fact that the rabbit is large and has a large marginal vein that will easily admit a 22 calibre needle. By this method the reaction is usually fully developed in twenty-four hours.

TUBERCULOSIS AND THE GENERAL PRACTITIONER*

W. A. Claxton, M.D.,
Jacksonville.

The management of persons with tuberculosis is an ever-present problem for the man practicing general medicine whether he be in a city or in a rural community. While thousands of dollars are spent every year in research, to learn new facts about its cause, prevention and treatment, the general practitioner must continue his work of discovery and caring for tuberculosis with the facilities at his command. His work never ends.

It is with the problems that confront the general practitioner that I wish to deal today, and to retain some order in our discussion let us consider the subject under the headings of diagnosis, treatment, prognosis and prevention. Most of my remarks will be about adult tuberculosis as childhood tuberculosis is almost a subject by itself.

*Read before the Florida East Coast Medical Association, Orlando, October 20, 1934.

Diagnosis: There are, of course, all grades of involvement from the very small focus which can be diagnosed only by the x-ray to the involvement of the whole lung or major part of both lungs. The diagnosis of these early cases presents a problem which is not simple for anyone no matter how expert he may be and everything relating to the patient's illness must be taken into consideration. A careful history is very necessary. We must learn by persistent questioning whether the patient has ever lived with a person infected with tuberculosis. This may have been a member of the household, a neighbor, a nurse or servant. Most infections take place in childhood so we must go back to learn if anyone in the family died of a chronic cough during this early period of the patient's life. We should inquire regarding pneumonia, especially repeated attacks, influenza, typhoid and protracted illnesses of unknown cause. Any of these may predispose to tuberculosis or even be tuberculosis. A history of pleurisy is a frequent finding—probably 70% of persons with tuberculosis give a history of pleurisy, which may be spoken of by the patient simply as a pain in the chest.

The symptoms that we are likely to meet in tuberculosis are chronic cough with expectoration, tiredness, and weakness, sweating on slight exertion, loss of weight, loss of appetite, dyspnea, pleural pain in the chest which may be ascribed to rheumatism or neuritis, fever especially in the afternoon and possibly night sweats. These all lead us to suspect tuberculosis. The initial symptom may be a hemorrhage. Coughing up blood should always be regarded as a symptom of tuberculosis until a definite focus of bleeding is discovered which will absolutely rule out the possibility of pulmonary origin. Of course, all pulmonary hemorrhages are not from tuberculosis but we must prove that they are not. It is very rare to find a person with tuberculosis who does not cough. The person may say he doesn't but it will be found that he clears his throat and brings up muco-purulent sputum. He may even do this while you are questioning him and still deny that he coughs.

When we come to physical examination we may find many changes in the chest. Nearly every doctor has his own peculiar method of making a chest examination. He may rely on palpation, percussion, or auscultation or he may get a great deal of information from inspection and it doesn't make much difference how he goes

about it if he can rely on his findings and interpret them correctly.

Findings such as a shoulder drawn down, chest flattened on one side, diminished expansion on one side, dullness on percussion, increased vocal fremitus, increased whispered voice, prolonged expiratory breath sounds are all important and should be a part of the picture that leads to a diagnosis but the most important sign of all is the finding of rales in the upper part of the chest. Other signs are confirmatory, but rales in the upper part of the chest mean tuberculosis in 90% of the cases. On the other hand, rales in the bases of the lungs are not tuberculosis in 90% of the cases. They are caused by bronchitis, bronchiectasis or lung abscess and must not be called tuberculosis unless there is positive sputum or x-ray evidence of the disease.

There is a special technique for eliciting rales which should be used by all physicians looking for tuberculosis. This consists of getting the patient to breathe out as far as he can, give a forced cough and immediately breathe in. At the beginning of this inspiration after cough, rales can be heard plainly when there may be no indication of them on ordinary or even deep breathing. Hearing these posttussic rales in the apex of the lung will make a diagnosis of tuberculosis practically certain. When we have located an area where rales are present we should start at the extreme apex, where they are usually most pronounced, and with the patient continuing to breathe out and cough we should go down the chest front and back to see how far these rales extend. This gives us an idea of the extent of the disease in that lung. Then we should examine the other lung the same way.

Treatment: When we have determined that a person has pulmonary tuberculosis we should determine what he needs in the way of treatment. This is dependent on the degree of activity of his disease, the length of time he has had it and to a certain extent on his finances. If he is ill he should be put to bed. By ill, I mean showing symptoms of activity such as fever, night sweats, loss of weight and other evidences of toxemia. We find many persons who have had the disease for from five to twenty years who come under the chronic fibroid classification and who do not need to be put to bed. All they need are certain restrictions in their daily routine which will prevent them from getting worse. To put these persons to bed would make them worse as it would destroy all their interest in life. In an early active case, the patient should be put in bed and kept there 24 hours a day until his temperature has been normal for several weeks and he has regained his lost weight. He should not be allowed to get up as soon as he begins to feel better; he should be watched very carefully and kept under observation for from three to five years. If he can afford it, he should be sent to a good sanatorium for from six months to one year where he can be taught by instruction and example to "take the cure."

Not very many years ago it was thought that no one could recover from tuberculosis in Florida. I see them getting well all the time. I meet and hear of persons who were sent to Florida to die twenty years ago who are well as far as activity goes and are doing all kinds of work. It is dangerous to predict what will happen to an early or moderately advanced case. The patient will upset your prognosis and often get well or get worse regardless of the treatment he takes.

When we begin to consider treatment we find that in recent years treatment of tuberculosis has changed considerably. The basis of all tuberculosis treatment is still: rest, good food and fresh air just as it has been, but in addition to these it has been learned that there are certain elements of diet that may accelerate recovery. The principal change is the addition of cod liver oil and either tomato juice or orange juice to the diet. I am a great believer in cod liver oil and believe that this or some of its concentrates should be given to every tuberculosis patient.

The second form of treatment is collapse therapy. When we observe the work done in well-equipped sanatoria over the country we find that 40 to 60 per cent of the patients are having their lungs collapsed in some way. There are three methods of collapsing the lung—pneumothorax, phrenicectomy and thoracoplasty.

Pneumothorax is the most common form of this collapse therapy. There should be some one doctor in every large town who is prepared to perform this operation, which is relatively simple and takes but little time. Phrenicectomy, or cutting the phrenic nerve to paralyze the diaphragm on the affected side, is beneficial in some cases and should be tried if pneumothorax is not successful. Thoracoplasty is a serious major operation and should be done only by a man trained in chest surgery. No patient should be considered

for collapse therapy until a thorough x-ray and clinical study has been made.

There are a few points that I want to mention as being of especial significance:

(1) Beware of making a diagnosis of tuberculosis from hearing rales in the base of the lung. 90% are not tuberculosis.

(2) Small cavities are not easily discovered by physical examination, sometimes even large cavities escape detection.

(3) Sputum reports that come back from the laboratory marked "loaded with tubercle bacilli" usually indicate a cavity.

(4) If you find a cavity, begin to think about pneumothorax immediately.

(5) Fibrosis in the lung is a favorable prognostic sign. If we have fibrosis we have resistance to the disease.

(6) Do not expect to find physical signs of tuberculosis in the childhood type of disease. You must make your diagnosis by x-ray and not consider that a positive tuberculin test indicates tuberculosis until confirmed by x-ray.

(7) Have good x-ray films on every case of tuberculosis or suspected tuberculosis. Even if you are sure of a diagnosis the x-ray will reveal pathology that you cannot determine by physical examination and a periodic x-ray examination will give you a definite picture of the progress your patient is making.

(8) When the diagnosis is made and confirmed by x-ray, study the patient, observe his reaction to treatment. Make each patient an individual problem and work out the best treatment for that particular patient.

(9) Also, when you have made a definite diagnosis, tell the patient that he has tuberculosis. It will save much embarrassment in the long run.

Prevention: Tuberculosis is passed on from one person to another by close contact. An open case of tuberculosis in a household can infect all the children in the family. Insist on keeping the children away from the patient and teach the patient not to scatter bacilli all through the house. Discourage the belief that adults will get tuberculosis from a patient. It is possible but happens so seldom that the danger may be ignored. Many patients are thrown out to die on account of this unwarranted fear. The greatest benefit that we can hope for at present is a state sanatorium to take care of tuberculosis, to cure the curable case, to protect the relatives of the hopeless case, to create an interest in tuberculosis among the physicians and the public, and eventually to reduce the death rate from this disease.

A PROPER EVALUATION OF THE PSYCHIC ELEMENT IN MEDICAL AND SURGICAL PRACTICE*

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"If there is any one phase of medicine which predominately demands study for the benefit of mankind in the coming century, it is that concerned with the mind of man rather than with his body." Morris Fishbein, M.D.

"The era of exclusive somatic medicine seems to be drawing to a close and a distinct drift is noticeable toward a psycho-somatic conception of disease." George H. Kirby, M.D.

"One of the tasks of the 20th century is to take possession of the great field of psychology. It is a region of untold interest and a great resource of power. No wonder man accepts the challenge to discover the wealth hidden here. Fortunate the man who keeps his poise while investigating and more fortunate still is he who comes back with wheat instead of chaff." E. L. House, M. D.

The foregoing statements indicate a growing interest in the psychic element in the practice of our guild and constitute at least a partial justification for the presentation of this paper. I am not a psychiatrist and claim no special knowledge in this field. A backward glance over the past years and daily observations prompt me to offer a plea for a better appraisal of the psychic element in the patients that visit our offices from day to day. I do not expect to present any new ideas but simply to suggest a better understanding and recognition by the physician in his daily routine of the three-fold nature of our patients—the physical, the mental, the spiritual.

It was Ian Maclaren who said: "There are three levels to life—the first level is where one eats and drinks, the second level is where one reads and thinks, the third level is where one loves and prays."

The famous declaration made by Virchow at the congress of Rome over fifty years ago has ceased to dominate medical thought. On that occasion he said: "There are no general diseases. From now on we shall recognize only diseases of the organs and cells." Psychology has made such a conception obsolete. Psychology is destined to exercise a humanizing influence on the practice of medicine through the emphasis which it places on the study of human emotions and human relations. Under this broader view, medi-

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cine of the future will extend its interest more and more beyond the laboratory, the microscope and the test tube.

It will consider the larger problems of human distress, emotional difficulties, personality adjustment and conduct disorders. This will be a natural consequence of the conception of the patient as a psychosomatic unit. The work of the immortal Virchow will stand as a master achievement in the annals of medicine even though he failed to recognize the psychic element in disease. As we look back half a century over the work done by the author of *Cellular Pathology* we marvel that he could have overlooked this master function of the mind. This simply proves that no one man can grasp the whole of medical truth.

Mental abnormalities have been in evidence in all lands from the beginning of civilization. The most drastic measures, even sterilization, have failed to arrest them. In spite of our many institutions, foundations and commissions for the study and alleviation of mental disease, neurologists agree that psychic disorders are increasing. Yet the tactful physician, with a painstaking and sympathetic interest in each case, can do much to reduce their prevalence and mitigate their distressing effects.

The economic burden of mental diseases is very great. In eight years the voters of New York approved bonds totaling 224 million dollars for state hospitals. Many more millions were required for maintenance and care. That indicates the money cost of mental disease in one state alone. See what staggering proportions the figures would assume when multiplied by 48 states.

There are in the United States 631 registered hospitals for mental and nervous diseases. Their total capacity is 427,343 beds, but they carry 445,867 patients. That means they contain 18,524 patients above their normal capacity. In addition to these, we have 527 mental hospitals not registered. These have a capacity of 15,791 beds. This increase in mental and nervous diseases is probably accounted for by our changed living conditions and community environment.

People are rushing from the country to the city. The era of quiet living on the peaceful farm has passed into history. It has been relegated to the horse and buggy days of the past. When farm life was profitable and popular, people rose with the sun, did a full day's work and went to bed at dark. Now they tramp the hard streets of the city night and day by the million. They have left the kerosene lamp back on the old homestead and rushed to the urban bright lights with its night clubs, boxing bouts and nerve-exciting entertainments. These changed conditions make it important for us to increase our understanding of human nature in health and disease to the end that we may more readily detect any tendency in our patients' departure from normal mental manifestations.

The mind contains traces of all emotional, mental and volitional activities and reactions of the past. Just so, both mind and body are the sum total of all psycho-physical activities and reactions of this life. It is also the repository of much that extends back into the evolutionary history of our progenitors.

We should recognize the complex nature of man and that many of the symptoms we see in patients are of psychogenic origin. If emotional conflicts are not found and eliminated they will be repressed by the patient and merge into tendencies, complexes and psychoses. Repression increases the force and danger mentally, as compression of gas or gun powder increases the force of its explosion when it lets loose.

After sickness and worry, the mentality becomes fatigued and depleted physiologically rather than pathologically. The same is true of senility. Many have been committed to psychopathic institutions who were merely worried and depleted in mind and body. Their mental and emotional disturbance was physiological, not pathological. They needed only rest and care. Incarceration plunged them into a fixed pathological mental state. The social disgrace of their commitment proved a mental shock so great as to impede or preclude recovery.

Thousands have been adjudged insane who should never have been brought into a lunacy court. Others have been hailed before a sanity commission who were less insane than the plaintiffs who made the application for the hearing. We should protect such patients.

Patients often repress and conceal a disturbing emotion such as fear of some incurable disease, permanent invalidism, premature senility or of impending insanity. Some fear they will lose their sexual power. They dread to disclose this to any one—even to their physician, and yet if he can lead such patient to a free confession of his mental conflict he finds relief and exultant delight in unburdening his mind.

After a round of physical examinations, x-rays, laboratory tests, etc., without finding any definite physical pathology we should inquire into the

thought life of the patient. This will include his home and domestic relations, business worries and problems, social activities and very important the sex proclivities.

While we cannot all become expert psychiatrists we can be on the alert to give consideration to the elementary aspect of psychopathology. A few years ago thousands of patients in hospitals under the designation of "shell-shock" indicated that we had not been awake to the number of physical diseases that could be caused by emotional factors. In peace-time practice we settled back to a complacent attitude and apparently assumed that the psychic element needs little attention. The fact is that much "shell-shocking" is still going on in the nervous systems of the men, women and children that daily visit our offices. Mental and nervous shocks are not confined to soldiers in the trenches. Emotional conflicts are occurring in our patients in peacetime and if they are not detected and relieved will result as disastrously as those caused by explosions in war. Dr. Hunt says: "What has been so obvious in the war neuroses is just as common in the battles of civil life only the symptomatology and mode of onset is less dramatic."

Strecker says: "The patient's mental and emotional conflicts should be recognized by us as real dynamic facts and factors, every whit as actual and important as catarrhal inflammations of the nasal mucous membranes, ptosis of the stomach, bronchial thickening in the chest, muscle imbalance in the eye, endocrine dyscrasias or the demonstration of the Koch bacillus in the sputum."

All men, women and children have emotions and emotional conflicts, and some are affected physically by them.

You have seen pylorospasm and spastic constriction of the colon due to emotional shocks or mental conflicts. Angina pectoris, exophthalmic goiter and diabetes exhibited up and down fluctuations depending on the emotions. This is the realm of the phantom tumor, false pregnancies and other well-known visceral manifestations of the psychoneuroses.

The causes of mental maladjustment are various and many. Aside from those arising from emotional conflicts, Dr. Clark believes focal infections in the ear, nose and throat are frequent causal and aggravating factors. He believes these should be even more thoroughly searched out and eradicated in psychopathic patients than in those of normal mentality.

Bainbridge finds mental diseases are caused by numerous bodily ailments and, on the other hand, many bodily diseases are the direct result of mental ills. It works both ways.

Jones says eye stress is frequently a cause of mental disturbances and these should have proper cycloplegic correction. He declares this may change the patient's whole course of life to a higher plane.

White believes that a great deal of what heretofore has been regarded as hereditary is now considered individual and due to causes which are preventable. He is impressed by the frequency with which mental disorders occur in association with foci infection in the sinuses, teeth, tonsils, thyroid gland, intestines, prostate and ovaries.

Psychology is an interesting and profitable study that may be pursued with a fair degree of success by every physician. It is distinctly a branch of medicine. It has not received everywhere the attention from physicians to which it is entitled. We cannot all be specialists in mental diseases, yet we may acquire at least a modicum of skill in detecting and correcting mental and emotional discords.

Like tuberculosis and cancer, mental abnormalities should be sensed in their incipiency and appropriate measures instituted at once. In earlier days, tuberculosis was frequently not recognized until far advanced. At that late hour no physician was needed to diagnose the case and no treatment was required. The neighbors made the diagnosis and the undertaker did the rest.

We now save tuberculosis and cancer patients by early diagnosis and treatment. In the future we shall arrest mental declension before it passes into total eclipse.

Psychopathology includes any form of healing which has for its object the treatment of disease by mental influence. If physicians fail to supply psychopathic patients the treatment they need, these will fall into the hands of laymen who are self-styled psychoanalysts unfit to attempt such delicate work. Psychopathology is distinctly a phase of medicine and we must occupy the field or others less qualified will step in.

Mental hygiene should begin at birth. When a babe is born its brain is like a blank phonograph cylinder ready to receive the impression. The wax is soft, the impressions are easily made. The nature of the impressions determine the character and destiny of the child. Hence at the moment of birth is when the doctor's responsibility begins. He may give some directions as to what stimuli shall be permitted to stamp their impressions on this sensitive plate.

Ebaugh says: "Existing facts indicate that one-

half of the admissions to mental hospitals could be avoided by complete studies and guidance of behavior during childhood and adolescence." Child care is the most important task of physicians and parents.

Some laymen have dared to attempt psychoanalysis. Wile thinks this to be a serious mistake. He believes that physicians only should be permitted legally to employ psychoanalysis for therapeutic purposes. He regards it as a thoroughly unsafe instrument in the hands of persons without medical training. It involves an instrument that is sharp, that has two edges and that is not without danger when applied by those unskilled in its use and unaware of its limitations and contraindications.

The vital organs are influenced by various psychic and emotional states. Neural energy is constantly flowing over the nerve trunks to the various organs. In this flow of nervous energy two great principles are involved—namely, excitation and inhibition. Without inhibitory control there can be no orderly regulation of neural activity. Excitation implies a discharge of neural function, while inhibition indicates its diminution or suppression. These two functions of the nervous system are complementary, and their cooperative checks and balances insure the harmonious regulation and coordination of all somatic and psychic functions. A considerable disturbance of this well-balanced relation between excitation and inhibition constitutes a neurosis, psychosis or psychopathology.

In every well-organized office or clinic the taking of the history, the physical examination, the laboratory tests of the urine and blood are now carried out in practically every case. But we fear equal diligence in examinations for the recognition of psychic causes of physical diseases is not always exercised. This may in part account for the number of cases that slip through our hands, pass from one doctor to another, then to the cults and nostrums, finally to the county jail and lunacy court. If psychic examinations were carried out systematically along with the physical tests in the routine practice, the incidence of mental disease might be held in abeyance or perhaps reduced.

The power of suggestion: Suggestion is that impression made on the human mind sufficient to change its course of action. No man knows what hour will bring to him a suggestion that will cause him to change his business, his residence or his profession. This mighty power comes through the spoken word, the look, the sign or gesture. The mother of Moses gave him a suggestion when he was a boy. That suggestion grew until it shook the foundation of Pharaoh's throne and delivered three million Jews out of Egyptian bondage. That suggestion enabled Moses to liberate a horde of Hebrew slaves and organize them into the most powerful nation that ever figured in history. That suggestion developed the man who gave the world the Ten Commandments and the Law which for 3500 years has been the foundation upon which every civilized nation has built its statutes. The wise suggestion of that mother changed the history of the world.

A physician once told a woman in the presence of her twelve-year-old son that he had a serious heart ailment and would never be able to engage in athletics. He gave up active sports and confined himself to the house. He heard his physician say he was liable to drop dead if he exerted himself. This hung over him like a pall. He grew up walking continually beside the specter of fear. He developed a psychopathic personality; a life without purpose. His doom was pronounced by the unwise suggestion of his physician.

Man's spiritual nature: Job says: "There is a spirit in man." There is a distinction between spirit and mind. They are expressed by different Greek words. Spirit transcends both mind and matter. Ruskin says: "The basest thought possible concerning man, is that he has no spiritual nature." Spirit as distinguished from mind seems to be invested with an ethical quality. It is in Man's spirit that conscience resides. It is the capacity by which he may apprehend and reflect God.

The psychopathic patient is out of harmony with himself and his environment. He may also be out of harmony with his God. Man is a religious being and often the appetites of his body conflict with divine precepts. His conscience may need help.

A psychiatrist says: "It is our rare privilege to bring patients into right spiritual attitudes with the Divine. There is much satisfaction in relieving a sin-laden soul."

If we cannot give our patients relief in their maladjustments they will learn to regard us as mere dispensers of pills and potions and turn to other sources for leadership when in trouble whether mental or physical. We will minister to the whole man—body, mind and spirit. This delicate interdependence between mind and body presents a difficult task and challenges the finest discretion and the best judgment on the part of the physician and surgeon.

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DR. JOHN GORRIE MEMORIAL FOUNDATION

The John Gorrie Memorial Foundation, chartered in Florida one year ago, is an organization with a two-fold purpose. It seeks first to honor permanently Dr. John Gorrie, who, while practicing medicine in Apalachicola, Florida, and striving to devise methods of preventing and of treating fevers by lowering the temperature of rooms, invented and constructed the first machine to make ice in quantities practical for use. In this achievement Dr. Gorrie takes precedence among those pioneers who gave to the world the benefits of artificial ice, for his machine antedated similar inventions by several years. Out of his work have grown some of the later methods of refrigeration and air conditioning.

The second objective of the foundation is to establish a memorial which will be of direct benefit to people in need. Certainly this sort of remembrance would please Dr. Gorrie much more than one expressed in stone, on canvas or in words. The foundation plans to provide hospitalization for the needy in the town where Dr. Gorrie perfected his invention of far-reaching importance, and also to carry on aggressively a nation-wide fight against cancer.

The means chosen for battling this disease are: (a) carrying on dignified publicity through reputable channels to acquaint the laity with the early symptoms of cancer; (b) bringing to existing medical organizations physicians expertly trained and especially experienced, who will help the local practitioners with their problems of handling cancer, the personnel of this service being composed of physicians who are neither practicing medicine nor are connected with any organizations of practicing physicians; (c) holding diagnostic clinics at the wish of the local physicians, conducted by skilled diagnosticians and pathologists who will attempt no treatment but will direct the patients to their own physicians; and (d) establishing for patients who are indigent or of limited means a revolving loan fund to enable them to secure proper medical treatment.

The ice manufacturers of Florida are so impressed with the motives and objectives of the foundation and are so desirous of perpetuating the memory of the physician who has made their organization possible that they are raising funds with which to begin the establishment of an endowment for the work of the foundation. It is their purpose to enlist the cooperation and aid of ice manufacturers throughout the United States. They will begin the collection of funds by observing "Ice Week" from August the 11th to the 17th, inclusive, and during that time will contribute 14 per cent of their income each day.

On the board of directors of the John Gorrie Memorial Foundation are several members of the Florida Medical Association, who are heartily enthusiastic about the Foundation and believe it is sponsoring a movement which will culminate in the outstanding achievement thus far attempting for cutting down the death rate from the second most deadly disease—cancer. The executive committee of the Florida Medical Association included in its report at Ocala a recommendation that the Foundation be endorsed, and the Association readily gave its endorsement. It is our conviction that if such a noble organization can be made to succeed, Florida may claim the distinction of having one of its physicians honored in a manner which will bring to those suffering from cancer benefits comparable to the good which has accrued to mankind from the epoch-making invention of a machine for producing artificial ice.

Proclamation

STATE OF FLORIDA
EXECUTIVE DEPARTMENT
TALLAHASSEE

WHEREAS, there has recently been formed a Foundation chartered under the laws of the State of Florida to furnish a perpetual memorial to Dr. John Gorrie, the Florida physician, who in his efforts to relieve human suffering, first discovered and practically demonstrated, eighty-five years ago this Summer, the basic principles of artificial ice making and refrigeration as we know them, and

WHEREAS, through this physician's contribution to humanity, millions have been saved to lead useful, productive lives, suffering and distress have been lessened among other millions lying on beds of sickness, and medical science through his gift has been enabled to make great strides in many fields in preserving human life, and

WHEREAS, the Medical profession of the State and nation desire to perpetuate his memory by raising an Endowment that will make possible the carrying out by this Foundation of a nation-wide cancer educational campaign both to physicians and laymen, under the direction of nationally known authorities, to assist medical science in removing this dread disease as a world scourge, and

WHEREAS, the Ice industry of the State is also desirous of joining in the establishment of this Memorial to the man who discovered the principles on which their industry has been built and are now at work on a plan to make possible the Foundation's endowment by giving to it the average of one day's ice receipts each year, prorated over a week,

THEREFORE, I, David Sholtz, Governor of Florida, hereby designate the week of August 11th to 17th (Sunday through Saturday) inclusive, to be known as

DR JOHN GORRIE ICE MEMORIAL WEEK

and urge that the various civic clubs, together with all citizens of the State, cooperate with the plans of the Dr. Gorrie Memorial Foundation that the great humanitarian movement undertaken shall serve not only as a memorial to an illustrious son of Florida but as well be an incentive to all other men to render unselfish service to humanity.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Florida to be affixed at Tallahassee, the Capital, this 27th day of June, A. D. 1935.



Governor

ATTEST-

Secretary of State

CORRESPONDENCE

To the Editor:

MEDICAL LEGISLATION VERSUS FLORIDA LEGISLATURE

In my report at the meeting in Ocala as Chairman of the Committtee on Legislation and Public Policy I made the statement that I would inform the members of this Association just how the members of the Legislature voted on each and every medical bill. I shall first deal with the Senate.

Our bill designated as "A", the Medical Practice Act and designated as S. B. 147, passed the Senate without a dissenting vote.

Bill designated as "B" and S. B. 144 passed the Senate with twenty-five yeas, two nays, Gomez and McArthur casting the opposing votes.

Bill entitled "C", the narcotic bill, and S. B. 145, pased the Senate with one dissenting vote, Senator Gomez.

Bill entitled "D", S. B. 141, defining the word Physician, one dissenting vote, Senator Gomez.

Our Bills designated as "E" and "F" Senate numbers 12 and 143, were merged into one bill known as Senate Committee Substitute Bill 142, passed the Senate unanimously.

Our Bill "I", known as the Lien Bill, Senate Bill 148, met defeat in the Senate with thirteen yeas and eighteen nays, as follows:

Yeas—Bass, Clarke, Futch, Gomez, Lewis, McKensie, MacWilliams, Mann, Parrish, Sweger, Tervin, Touchton, Turner—13.

Nays—Adams, Beall, Harper, Lundy, McArthur, Nordman, Parker, Raulerson, Rose, Savage, Shelly, Shivers, Sikes, Smith (14th), Smith (29th), Tillman and Watson—18.

Our bill "J", requiring United States citizenship before being allowed to take the Medical Board, designated as S. B. 140, passed with two dissenting votes, Gomez and McArthur.

The Senate Committee on Public Health, Mann, Turner, Rose, Sweger and Touchton, reported unanimously favorable on all our bills and supported them when reported back for the final vote with the exception of Senator Rose, voting against the Lien Law. Just why these members were not in favor of physicians and hospitals collecting their accounts I am unable to understand, but I am of the opinion that if we start work now we will be able to overcome their objections in 1937.

The support we received from the Senate was nothing short of marvelous, and revealed the fact that our Senators were open minded and realized some rights and privileges in the safeguarding of our profession and public health measures.

THE COLOSSAL FLOP IN THE HOUSE

The Committee on Public Health in the House of Representatives was as follows: Dr. O. B. Hazen, Chairman; Warren, Williams (Holmes), Hubbell, McLin, Ward, Early, Banks and Rogers (Broward).

On this Committee we had some staunch and loyal supporters who voted one hundred per cent with us on every bill, namely, Hazen, Hubbell, Warren and Rogers. Some of the other members voted with us on our bills that other classes of practitioners did not object to. If other practitioners objected, they objected, no doubt conscientious objectors not fully aware of the danger lurking behind the reason motivating their objections.

Our Bill "A", Medical Practice Act, was supported by Hazen, Warren, Hubbell and Rogers, and opposed by Banks, Early, McLin and Williams.

Our bill "B", designating the Enforcement Act was unopposed.

Our bill "C", the Narcotic Act, was opposed by Mr. Early.

Our bill "D", definition of the word Physician, was opposed by McLin, Williams, Ward and Early, and was laid on the table under the Rules.

The Registration Act was unopposed.

The requirement for citizenship before taking the Board was unopposed,

These bills were reported out of the Committee on May 3rd, and were placed on the Calendar for third reading for May 15th. However, the time was taken up with other bills and these bills were left hanging on the end of the limb. I then sought advice from influential members of the House as well as our attorney, Mr. Gregory, and was advised by all that these bills could not be considered unless the Rules Committee placed them on Special Order. I received an appointment with the Chairman of the Rules Committee and he most earnestly assured me that the bills turned in by the Committee on Public Health would be placed on Special Order some morning or afternoon before the Session closed. Letters were then addressed to members of the House urging them to look out for these bills. Feeling

secure with more than two-thirds of the members pledged to support them and relying on the Rules Committee to give them a special order reading, nothing further was done until Wednesday night before the close of the session when I was warned by some of our staunch supporters in the House that these bills would not be placed on special order unless I could secure the cooperation of Mr. Bishop, Speaker of the House, and Mr. Robineau, Chairman of the Rules Committee. I personally interviewed Mr. Robineau, reminding him of his promise two weeks earlier and asking his cooperation at this time. Mr. Robineau then told me that I should have some pressure brought to bear on the other members of the Rules Committee and Mr. Bishop. A telegram was sent to Mr. Bishop and each member of the Rules Committee, expressing disappointment that the recommendation of the Public Health Committee was entirely ignored. On the last day, Saturday at noon, Dr. Hazen called me on the phone and said the Chairman of the Rules Committee would allow one of our pet bills to be placed on special order and passed. I selected those designated as "A", "B" and "C", in order named and then made a trip to Tallahassee and spent until midnight trying to get this measure through.

We were very fortunate in having the Public Health Committee unanimously vote to table some of the pernicious bills that were introduced. I hope that we will be able to have at least five or six physicians in the House and about two more in the Senate than we have now and that we will at least be able to have a speaker of the House who will show some consideration for the medical profession in 1937. We had many friends in the House who did everything in their power to get these bills on special order of the calendar, but it is very apparent that we did not have enough backing and influence with just one or two men who would have been able to turn the trick and were not as much in sympathy with our cause as I had been assured they were.

Now that you have a complete report from me, I hope that each County Medical Society will take an active part in supporting their Representatives who will pledge and prove themselves loyal to our cause.

(Signed) J. C. Davis, M.D.,
Quincy, Fla.

STATE NEWS ITEMS

The Orange County Medical Society extends an invitation to the members of the Florida Medical Association to attend its annual picnic and barbecue at Lakeside Park, Orlando, Saturday, July 27.

* * *

Dr. Nelson Black of Miami attended the annual meetings of the American Ophthalmological Society and the American Medical Association during the month of June.

* * *

Dr. James L. Estes of Tampa recently spent some time in Philadelphia doing work at the Urological Clinic of the Pennsylvania Hospital with Dr. Leon Herman.

* * *

Dr. Walter A. Weed of Orlando and Lakeland recently spent two weeks in Washington and New York studying special phases of roentgenology.

* * *

Dr. and Mrs. J. H. Lucinian and son of Miami have gone to Chicago where Dr. Lucinian will visit x-ray clinics and then fly to Rochester, Minn. to spend several weeks in the x-ray department of the Mayo Clinic.

* * *

Dr. C. D. Christ of Orlando recently spent a week in Baltimore, Maryland, attending a reunion of his class at the University of Maryland.

* * *

Dr. and Mrs. Ben H. Lawson of Winter Garden spent ten days of June at Washington, D. C. While there, Dr. Lawson attended the Shrine Convention.

* * *

Dr. Louis Orr, accompanied by Mrs. Orr, will spend six weeks in the West and Alaska. While in California, Dr. Orr will attend the meeting of the American Urological Association at San Francisco. Dr. and Mrs. Orr will return to Orlando about July 29.

* * *

Dr. Shaler Richardson of Jacksonville attended the meeting of the American Ophthalmological Society held in Hot Springs, Virginia, in June. Subsequently, he attended the meeting of the American Medical Association in Atlantic City.

Dr. E. S. Estes of St. Augustine, a member of the Staff of the Flagler Hospital since 1908, Chief Surgeon for the past 18 years, recently tendered his resignation as Chief Surgeon. Dr. Estes will continue as a member of the Staff.

* * *

Dr. Grady Page of Orlando, was in New York recently on a business trip.

* * *

Dr. and Mrs. James S. Grable of Tampa announce the birth of a son, James Stuart Grable, Jr., born on June 13.

* * *

Dr. J. A. Pines of Orlando has returned from a trip to New York, after an absence of one month. He attended the meeting of the American Medical Association at Atlantic City and took post-graduate work in roentgenology in New York City.

* * *

The State Board of Medical Examiners met in Jacksonville during the month of June. An election of officers was held, which resulted as follows: President, H. A. Day of Orlando; Vice-President, J. D. Raborn, Trenton; Secretary-Treasurer, William M. Rowlett, Tampa. One hundred and three doctors took the Board's examination. This is one of the largest groups examined in several years.

* * *

Dr. Spencer A. Folsom of Orlando is spending six weeks at the Mercy Hospital, Pittsburgh, studying electrocardiography under Mullins, a former pupil of Wilson of the University of Michigan. Dr. Folsom will return about August 1.

* * *

Dr. Frank Gray of Orlando, accompanied by Dr. Julian Quattlebaum of Savannah, recently spent two weeks in the Surgical Division of Mayo Clinic. En route, they stopped in Indianapolis to see the speedway races.

* * *

The annual banquet of the Staff of the Orange General Hospital, Orlando, was held on the evening of June 3. There was a good attendance, important business was transacted and all were unanimous in declaring that Miss Homer Harris, the new superintendent, was a caterer par excellence.

The regular annual meeting of the Florida State Radiological Society was held in the Harrington Hall Hotel, Ocala, on May 12, 1935. The first session convened at 10 a. m. and adjourned at 5 p. m. A luncheon meeting for members of the Society was held at the noon hour and was well attended. The usual round table discussions of interesting and puzzling cases proved unusually satisfactory. Quite a number of visitors who arrived before the sessions of the Florida Medical Association started were able to attend the Radiological Society meeting. Many of the visitors attending made favorable comments on the character of the meeting.

The next annual meeting of the Radiological Society will be held during the month of May, 1936, at Miami. The place and date for the semi-annual meeting have not yet been determined. The following officers were elected for the ensuing year:

President—Dr. W. McL. Shaw, Jacksonville.
Vice-President—Dr. F. J. Payton, Miami Beach.
Sec'y-Treas.—Dr. Gerard Raap, Miami.

* * *

With sixty-three members registered, the Florida Medical Association was well represented at the meeting of the American Medical Association, held in Atlantic City, June 10-14, 1935. Those registering from Florida were:

Allen, Bundy (delegate) ..... Tampa
Andrews, C. A. ..... Tampa
Barge, H. A. ..... Miami
Black, Nelson ..... Miami
Brown, Harold O. ..... Tampa
Bryans, Herbert L. ..... Pensacola
Calvert, Read N. ..... Orlando
Cleveland, Jack Q. ..... Miami
Coplan, Milton M. ..... Miami
Duncan, William P. ..... Tampa
DuPuis, J. G. ..... Miami
Ely, R. A. ..... Tampa
Ermshar, H. F. ..... Orlando
Estes, James L. ..... Tampa
Feaster, O. O. ..... St. Petersburg
French, Elmo D. ..... Miami
Grace, Charles C. ..... St. Augustine
Graves, J. Raymond ..... Miami
Halton, Joseph ..... Sarasota
Hanson, Henry ..... Jacksonville
Harris, Robert M. ..... Miami
Hayes, J. W. ..... Jacksonville
Herring, John A. ..... St. Petersburg
Ingram, L. C. ..... Orlando
Jeffrey, Stewart L. ..... Miami
Johnston, W. J. ..... Sarasota
Jones, Walter C., Jr. ..... Miami
Jones, W. Wardlaw ..... Dade City
Kennedy, David R. ..... Sarasota
Knox, A. W. ..... Sanford
LeBreton, Prescott ..... St. Petersburg
Lowe, Eugene C. ..... Miami
McEuen, H. B. ..... Jacksonville
Mallory, Meredith (delegate) ..... Orlando
Marr, N. M. ..... St. Petersburg

Mentzer, Claude G. ..... Miami
Metzger, Frank C. ..... Tampa
Milton, John D. ..... Miami
Mols, Edith P. ..... Tampa
Moor, F. Clifton ..... Tallahassee
Nichol, E. Sterling ..... Miami
Osincup, Gilbert S. ..... Orlando
Papot, Grace E. ..... W. Palm Beach
Pines, John A. ..... Orlando
Quillian, Warren ..... Coral Gables
Richardson, Shaler ..... Jacksonville
Silverman, Harry Z. ..... Miami Beach
Simpson, W. T. ..... Winter Haven
Smith, Marvin ..... Miami
Stewart, Joseph S. ..... Miami
Stone, Alvord L. ..... Tampa
Strickland, J. A. ..... St. Petersburg
Summerlin, J. L. ..... Gainesville
Taylor, H. Marshall ..... Jacksonville
Taylor, Joseph W. ..... Tampa
Taylor, T. W. ..... Sarasota
Thomas, Robt. Y. H. ..... Jacksonville
Vogt, F. A. ..... Miami
Wade, H. W. ..... St. Petersburg
Weiland, Arthur H. ..... Coral Gables
Weinkle, Barney ..... Miami
Williams, Carl A. ..... St. Petersburg
Youmans, Iva C. ..... Miami

* * *

Dr. Julius C. Davis of Quincy was a visitor at Radium Springs recently, where he attended the meeting of the Chattahoochee Valley Medical and Surgical Association.

* * *

On his trip north to attend the meeting of the American Medical Association, Dr. H. A. Barge of Miami stopped at Washington, D. C., to attend the Shriners' Convention.

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COMPONENT COUNTY SOCIETIES

DUVAL COUNTY MEDICAL SOCIETY

The June meeting of the Duval County Medical Society, held June 4 at the Mayflower Hotel, was the last meeting of the society until October. The following program was enjoyed:

"Hematuria," George Richardson.

"Pathological Hemorrhage," T. E. Buckman.

ORANGE COUNTY MEDICAL SOCIETY

The annual picnic and Barbecue of the Orange County Medical Society will be held at Lakeside Park, Orlando, Saturday, July 27. All members of the Florida Medical Association are invited to attend. A whole steer will be barbecued; there will be plenty of Brunswick stew and other trimmings. Several committees are planning to hold meetings during the picnic.

WOMAN'S AUXILIARY

TO THE
FLORIDA MEDICAL ASSOCIATION, INC.
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MRS. S. M. COPELAND
1356 Willowbranch Ave.,
Jacksonville, Florida

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MRS. L. C. INGRAM, Finance . . . . . *Orlando*
MRS. S. M. COPELAND, Press and Publicity . . . . *Jacksonville*

My dear Fellow-Members of the Auxiliary:

It was with a great deal of pleasure that my first official act as your president was to represent you at the 13th annual meeting of the Woman's Auxiliary to the American Medical Society held in Atlantic City, June 10-14, 1935. I only wish each of you could have attended with me and absorbed some of the inspiration I did from this delightful meeting.

The Auxiliaries of Delaware, Pennsylvania and New Jersey were hostesses and enough praise cannot be given these charming ladies for their many efforts in making our stay in Atlantic City one of comfort and enjoyment.

Members of the National Board had their first introduction to each other on Sunday night at a supper in the beautiful Claridge Hotel given by the Delaware Auxiliary in honor of the National President, Mrs. Robert W. Tomlinson of Wilmington, Delaware.

Monday was devoted to pre-convention board meetings and in the evening a "Get-Together Dinner" in honor of the visiting Canadian ladies. A very lovely musicale followed this dinner.

Tuesday morning was the annual Southern Auxiliary Breakfast. Dr. Marshall Taylor, President of the Southern Medical Association and a resident of Jacksonville was guest speaker.

At the open general meeting at 9:30 we heard the president's (Mrs. Tomlinson's) splendid report. The reports of all officers and chairmen of standing committees followed. They were all very interesting, especially the Organization Committee's report showing an increase in membership of 1,000 new members during the year making a total of 15,693 members. They also reported the organization of two new State Aux-



. . . . and a day ASHORE in HAVANA, gay, glamorous Capital of the romantic island of Cuba.

THE PLANS for the Sixty-Third Annual Meeting of the Florida Medical Association, Inc., which will be held on board the luxuriously appointed passenger liner "FLORIDA", include a day ashore in the beautiful city of Havana.

Golf, shopping tours, trips to beauty spots of the adjacent country, and the strange and unusual sights of this bit of the old world in America, will be a fitting climax to the three-day medical cruise of tropical waters.

• The illustrations above: (1) A market street in downtown Havana. (2) The gay crowd of a boulevard cafe. (3) Cuba's beautiful $20,000,000 Capitol building. (4) Native cafe in Havana. (5) Open-air market. (6) Beautiful residences adjoin the famous golf course of the Havana Country Club.

iliaries, New York and North Dakota. Hygeia Committee reported an increase of 2,138 subscriptions over last year, making a total of 4,674. The Program Committee reported that in the fall a new study envelope, "Heart Disease," would be printed for health education programs.

Tuesday afternoon from 4 to 6 we were entertained with a very lovely tea at the Traymore Hotel and that night attended the general meeting of the American Medical Association in the Auditorium of the convention Hall. Dr. McLester of Birmingham, Ala., was installed as the new president of the A. M. A. and the program of singing which followed was very beautiful.

The second general meeting of the Auxiliary on Wednesday morning was devoted to the reports of the 43 State Auxiliaries. Only three minutes were allowed for each state report and many valuable and interesting points were noted. Especially noteworthy was the work of one Auxiliary in stopping the advertisement over radio and in the newspaper in a large city of certain patent medicines that could not live up to their claims. This of course was done with the help of Dr. Cramp and their own county Medical Society. Many medical scholarships and benevolent funds for doctors were noted. It was a pleasure for me to read Florida's report of last year's outstanding work under Mrs. E. R. McMurray. This meeting adjourned to meet in 1936. Final registration showed present, National Board Members 38, Delegates 92, Members 730, Guests 850 and Canadian Guests 102.

The annual Auxiliary luncheon, a very beautiful affair followed this meeting in the Traymore Hotel. We had as one of our guest speakers Dr. Dafoe of Canada and he told us many interesting things about the Dionne babies.

Thursday morning was devoted to group discussions, a very helpful part of the entire meeting for new presidents, a lovely luncheon and style show followed and in the evening a very enjoyable, "Bring Your Husband Dinner."

In summing up the whole convention meeting I would like to leave this thought with you, the very important part in health education of the laity that auxiliary members can do, that in carrying out our health education program to be constantly under the supervision of our Advisory Board and to always keep before us the meaning of our organization name, Auxiliary—"That Which Helps."

Clara G. Veal,
President.



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A Boat Trip for 1936

As an Auxiliary to the Florida State Medical Association and as co-workers in the organization, we feel it a great privilege to assist the doctors whenever we can. Our great ambition now is to create enough interest among the Auxiliary members to insure the doctors of our whole hearted cooperation in sponsoring a boat trip for our next annual state meeting to be held in 1936.

A full account of the plans as were formulated by the House of Delegates at the last State Medical Meeting in Ocala were published in the June issue of the Florida State Medical Journal. If you haven't already read it, be sure to do so and let's begin now to save for this lovely trip which will no doubt be a great means of bringing us closer together and helping us to feel that oneness the aims and purposes of our organization. Let's hope these plans materialize and let's do our part to help make it a success.

* * *

Pinellas County Auxiliary

Mrs. Raymond K. O'Brien was elected president of the Auxiliary to the Pinellas Medical Society at its annual luncheon at the Lion's Beach Club.

Other officers elected were first vice-president, Mrs. Prescott LeBreton; second vice-president, Mrs. A. P. Roope; secretary, Mrs. Claude Wright; corresponding secretary, Mrs. F. S. Jennings, and treasurer, Mrs. B. L. White.

Nineteen members were present. The guests enjoying this occasion were Mesdames R. Stevens, C. P. Youmans, B. Wright, T. S. Tray, Reggie Aldworth, Joe Hodges, Ted Clarkson, N. W. Broadwater and M. Wadsworth.

* * *

Dade County Auxiliary

The Woman's Auxiliary to the Dade County Medical Society enjoyed a delicious luncheon at the Miami Colonial Hotel, June 10th.

A business meeting followed the luncheon with Mrs. H. A. Leavitt, the president, presiding. Booklets of the report of the Dade County Tuberculosis Association were distributed among the members. The Auxiliary voted to sponsor the booth sales of Christmas seals again this year. A report was given on the scholarship fund. Mrs. Frank Morrow and Mrs. Scheffel Wright were welcomed as new members in the Auxiliary.

Officers elected were: President, Mrs. E. J. Hall; vice president, Mrs. W. M. Goodson; re-



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cording secretary, Mrs. S. Arnovitz; corresponding secretary, Mrs. William J. Barge, and treasurer, Mrs. C. E. Tumlin. The next meeting will be early in November.

* * *

Duval County Auxiliary

The Duval County Medical Auxiliary met Thursday afternoon for the last meeting of the year, in the home of Mrs. H. A. Peyton on Riverside Avenue. The meeting was presided over by Mrs. Gordon H. Ira.

Mrs. E. W. Veal, new State president, having recently returned from the national convention in Atlantic City, gave an outline of the business and social activities of the meeting. A report on the state meeting held in Ocala in May was given by Mrs. S. M. Copeland.

The following officers were elected: Mrs. O. P. Broadbent, president; Mrs. J. H. Owens, vice-president; Mrs. J. W. Hayes, secretary; Mrs. Edward Jelks, treasurer. The gavel, decorated with a corsage of roses, was presented to Mrs. Broadbent by Mrs. Ira.

Mrs. T. G. Croft, program leader, gave a short outline of the work of the auxiliary during the six years of existence. Mrs. Herrman H. Harris, Mrs. S. E. Driskell, Mrs. W. W. Kirk, Mrs. E. W. Veal, Mrs. G. Beckman and Mrs. Gordon H. Ira, past presidents, were introduced in the order in which they held office and were presented with corsages of roses. Mrs. Ira held the president's chair two consecutive years. Each past president gave a report on the work accomplished during her term of office.

Mrs. Broadbent, new president, asked for cooperation during the coming year.

Mrs. H. A. Peyton, assisted by Mrs. Ira, Mrs. A. K. Wilson, and Mrs. S. M. Copeland served delicious refreshments. During the social hour members enjoyed looking through the scrap book of the auxiliary which has been kept by Mrs. S. M. Copeland.

Those present were Mrs. O. P. Broadbent, Mrs. Gordon H. Ira, Mrs. G. Beckman, Mrs. E. W. Veal, Mrs. W. W. Kirk, Mrs. Herrman H. Harris, Mrs. T. G. Croft, Mrs. Banks H. Goodale, Mrs. C. W. Johnson, Mrs. L. Y. Dyrenforth, Mrs. T. E. Morgan, Mrs. L. G. Lyerly, Mrs. A. B. Quasser, Mrs. H. M. Taylor, Mrs. H. A. Peyton, Mrs. W. G. Harris, Mrs. G. W. Richardson, Mrs. L. V. Tyler, Mrs. S. M. Copeland, Mrs. T. K. Drew, Mrs. T. W. Krueger, Mrs. J. H. Mitchell, Mrs. A. K. Wilson.

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Laryngoscope, 1935, XLV, 149-154★

SEE ALSO
Pharmacology of Inflammation: III. Influence of hygroscopic agents on irritation from cigarette smoke.
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245★

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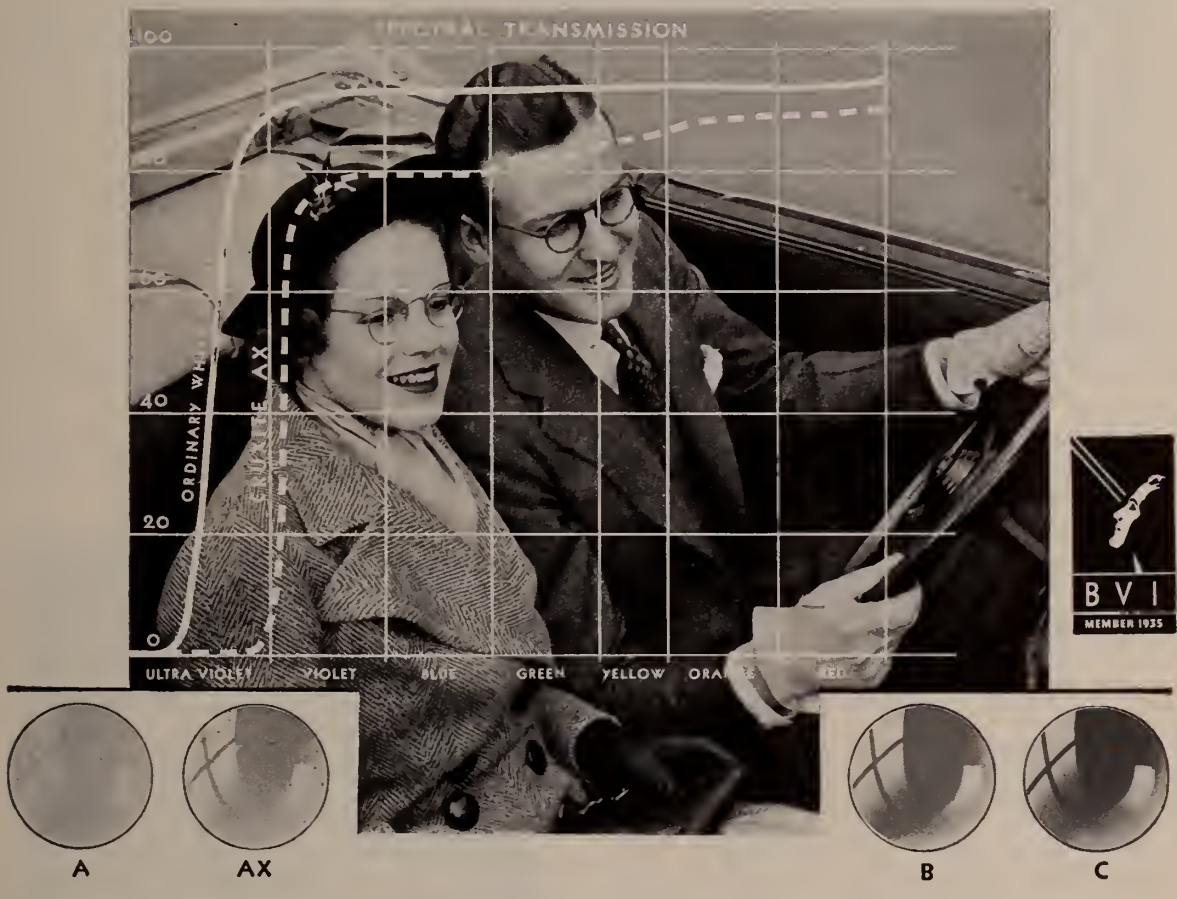
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The Borden Digest

summary of june issue

Pasteurization of all market milk is universally recognized by physicians and other scientists as a desirable and necessary safeguard for the public health. The judiciary also recognizes this wise principle, as shown by the review of court decisions on pasteurization requirements which is outlined in Abstract No. 65.

A plea for pasteurization of milk and a statement of the duty of physicians in attempting to secure efficiency in the process is contained in the editorial mentioned in Abstract No. 66.

Vitamin D milks are the subject of the bulletin reviewed in Abstract No. 67, in which the various methods for enriching milk in vitamin D are described and the advantages of fluid and evaporated vitamin D milks are set forth. Ice cream is stated not to be a suitable dairy product for enrichment in vitamin D.

Laboratory examinations for milk handlers are discussed in the paper which is the basis of Abstract No. 68. Extensive data reveal that streptococcus infections are the most prolific sources of milk-borne epidemics due to contaminated raw milk supplies.

The effects of freezing upon milk and cream are set forth in the article summarized in Abstract No. 69. A practical method for rapid freezing of partially concentrated milk is proposed in this paper.

"Acidosis" in children is usually a symptom of infection rather than a morbid entity, according to the material presented in Abstract No. 70, in which methods of treatment for this condition are advised.

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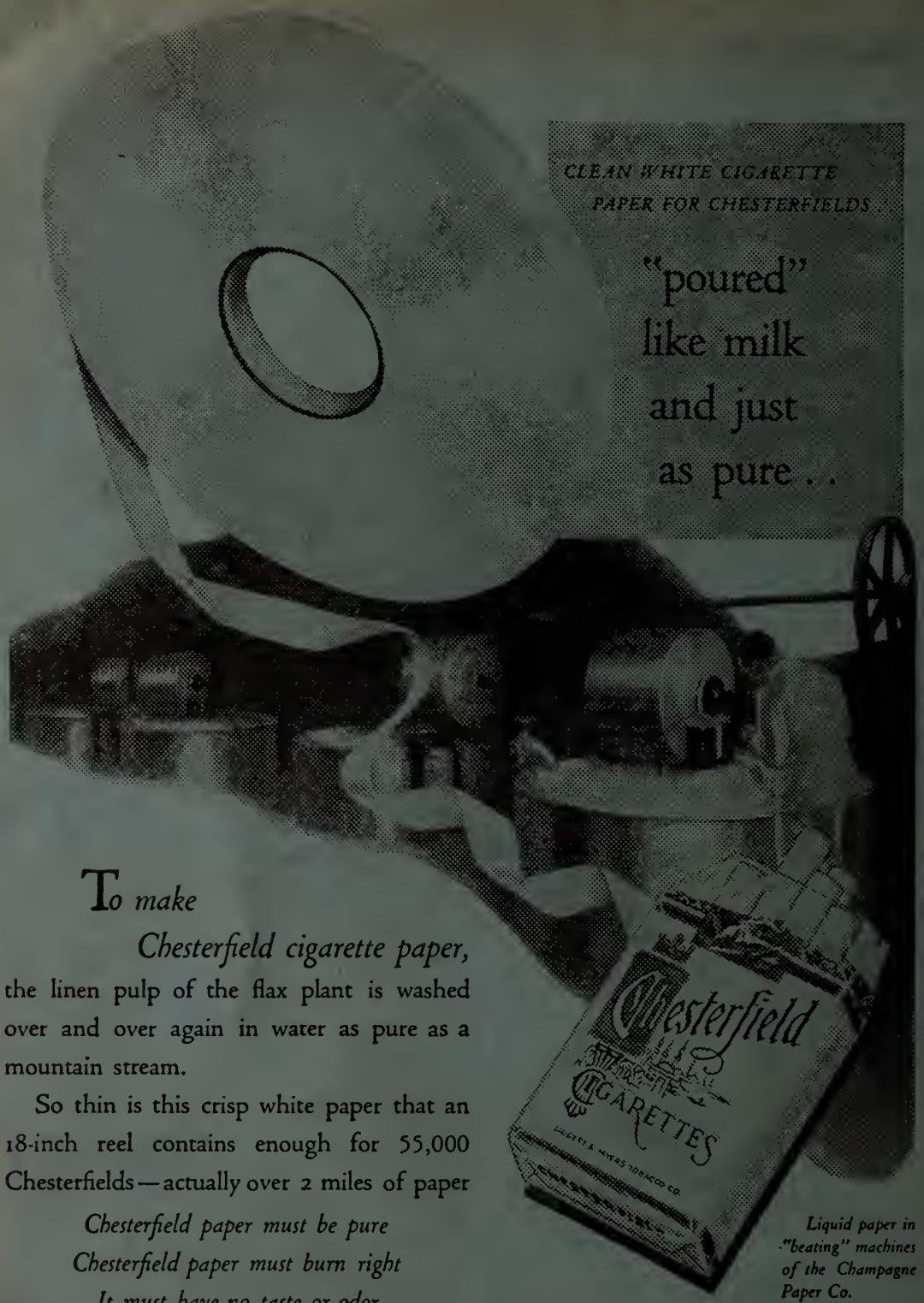
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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid
		Date	Time	Place	Luncheon?	
Alachua	Harry M. Merchant, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	92%
Bay	Allen H. Miller, M.D., Millville.					80%
Brevard	Bob Schlernitzauer, M.D., Rockledge.	2nd Tuesday		Varies	Yes.	77%
Broward	Robert E. Blount, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	95%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	98%
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.	2nd Tuesday	8:00 P.M.	Varies	Yes.	100%
Duval	Charles B. Mabry, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	63%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	55%
Hillsboro	John S. Helms, Jr., M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	91%
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	83%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	95%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	82%
Madison	Geo. O. Davis, M.D., Madison.					100%
Manatee	W. D. Sugg, M.D., Bradenton.	3rd Tuesday	7:00 P.M.	Whitfield Country Club Bradenton	Yes.	75%
Marion	Richard C. Cumming, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	100%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	John A. Pines, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	96%
Palm Beach	Lloyd J. Netto, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	100%
Pasco-Hernando-Citrus	John J. Bourke, M.D., Dade City.	2nd Thursday	7:00 P.M.	Varies	Yes.	100%
Pinellas	O. O. Feaster, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg. St. Petersburg	No.	94%
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	100%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	86%
St. Johns	John L. Bennett, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okeechobee-Indian River-Martin	E. B. Hardee, M.D., Vero Beach.	3rd Thursday	8:00 P.M.	Varies	Yes.	71%
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	93%
Seminole	J. T. Denton, M.D., Sanford.	2nd Monday	7:00 P.M.	City Hospital Sanford	Yes.	100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	C. A. O'Quinn, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	100%
Volusia	Hugh West, M. D., DeLand	2nd Tuesday	7:30 P.M.	Varies	Yes.	87%
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



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VOLUME XXII
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Jacksonville, Florida, August, 1935

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NEXT SESSIONS

Florida Medical Association, S.S. Florida, May, 1936
American Medical Association, Kansas City, Mo., 1936.
Southern Medical Association, St. Louis, November 19-22, 1935

Entered as second-class matter under Act of Congress of March 3, 1879, at the Postoffice at Jacksonville, Florida, October 23, 1924

Loose Stools in Infants

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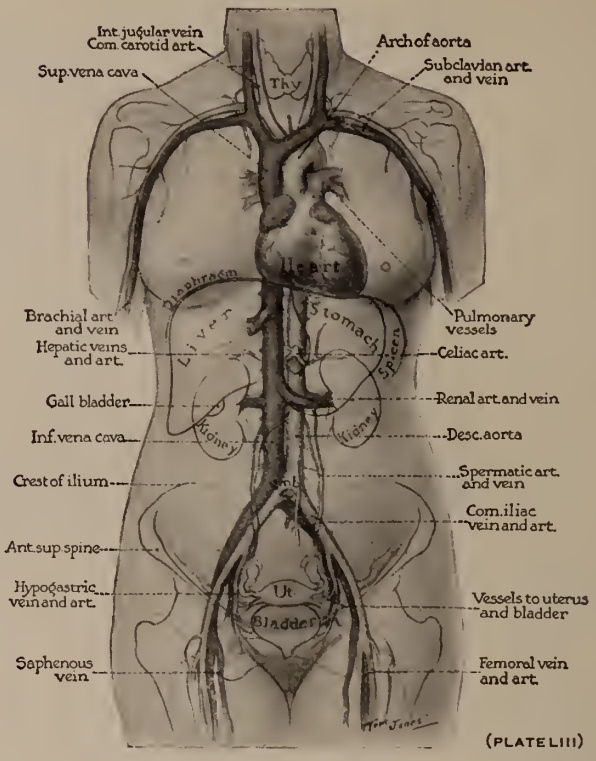
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(1) The Art of Preserving, M. Appert, Black, Parry and Kingsbury, London, 1811.

(2) Thermal Process Time for Canned Foods, C. O. Ball. Natl. Res. Council Bulletin, v. 7 No. 37, 1923

(3) Preventive Medicine and Hygiene, M. J. Rosenau, Appleton-Century, N. Y. 5th Ed. 1927.

This is the third in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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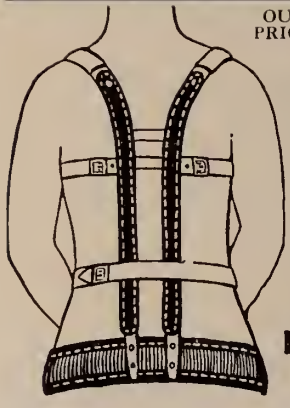
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SHRINKAGE OF THE TURBINATES EFFECTED BY BENZEDRINE INHALER IN THE TREATMENT OF HAY FEVER



FIG. (*i*) 3:02 P.M. *Before Treatment*

CASE No. 1 (B.C.) Female. Colored. Acute hay fever. Seen at Nose and Throat Clinic of a Philadelphia hospital, May 28, 1934. The inferior turbinates were badly engorged and there was considerable lacrimation as seen in Fig. (i). Following four inhalations (two in each nostril) from Benzedrine Inhaler, the turbinates were shrunk as in Fig. (ii) and there was relief from lacrimation.



FIG. (*ii*) 3:07 P.M. *After using Benzedrine Inhaler*

These pictures were made by William B. McNett from actual cases seen at the Nose and Throat Clinic of a large Philadelphia hospital. They illustrate strikingly the beneficial effects obtained by inhalation from Benzedrine Inhaler during an acute attack of Hay Fever. They also confirm previous publications as to the value of Benzedrine in this condition.

"The vasomotor and 'hay fever' group was likewise benefited." *Bertolet, Medical Journal & Record, July 20, 1932.*

. . . results in hay fever "were definitely encouraging. There was definite proof, in this type of case, that the amount of secretion was diminished, the subjective itching and feeling of fullness relieved and decongestion of the mucous membrane accomplished." *Byrne, New England Journal of Medicine, Nov. 23, 1933.*



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SHRINKAGE OF THE TURBINATES EFFECTED BY BENZEDRINE INHALER IN THE TREATMENT OF

HAY FEVER



FIG. (*i*) 2:20 P.M. *Before Treatment*



FIG. (*ii*) 2:35 P.M. *After using Benzedrine Inhaler*

CASE No. 2. (M.S.) Female. White. Acute hay fever. Seen May 28, 1934 at the Nose and Throat Clinic of a Philadelphia hospital. 2:20 P.M.—Turbinates dry and engorged. Two inhalations from Benzedrine Inhaler. 2:22 P.M.—Turbinates moist and dripping—some shrinkage. 2:35 P.M.—Maximum shrinkage and complete symptomatic relief. Small spur visible on turbinate.

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OBSTETRICAL LIABILITIES*

S. R. Norris, M.D.,
Jacksonville.

As you all know, the question of maternal and infant mortality and morbidity has been the question of much investigation and discussion lately. The spotlight of public attention has been focussed upon this subject by the publication of investigations made by the Children's Bureau, the recent report of the New York Academy of Medicine, many medical organizations, and articles in many lay magazines. None of these have been very complimentary to physicians, some downright derogatory.

Florida has the unenviable record of having one of the highest maternal mortality rates of any state in the union. The first logical step in correction of such a condition is to have an audit and tabulation of our results, and then take necessary steps for its correction.

I asked the head nurse of the Maternity Department of one of our local hospitals to make a list of all obstetric liabilities—both maternal and fetal—for the past few years. Then she and I together analyzed all these cases, approximately 2,000, seeking to find the reason for the liability or casualty. These reasons automatically fell into several chief groupings, blame in some cases falling on the patient, some cases not preventable, but all too many on the attending physician. It is this last group that I wish to discuss. I will not quote statistics, nor give any long technical dissertation, but will deal only in generalities, and offer a few suggestions in each group. I am not trying to censure, but to seek improvement. To guarantee impartiality and eliminate the personal element no physician's name was attached to any case, and quite frequently I found that I had been heaping some very harsh criticism on my own head.

From the maternal standpoint the most frequent groupings were toxemias, the various hemorrhages, Cesarean section, dystocias of various kinds, and sepsis; from the fetal side, prematurity, toxemias, abortions, accidents of labor, pituitrin and hemorrhages of mother.

So much has been written and said about the toxemias of pregnancy that we hesitate even to mention them. But this makes up one of the greatest indictments against the medical profession. Most of the severe cases are preventable. All we need for the early detection of the average case is a blood pressure apparatus, urinalysis, frequent visits with the patient, scales, and prompt recognition of clinical and subjective symptoms. These things are available to us all. We have the knowledge, but in spite of this toxemias are still too prevalent. There is only one conclusion to draw. Some of us are careless or negligent. This is borne out by history given by these patients of lack of proper prenatal care and advice. Of course, we cannot be held responsible for cases that had not consulted a physician until in stage of acute toxemia.

I do not intend to give a full treatise on toxemias, but merely wish to mention a few points that were brought out by cases reviewed. Our culpability in those cases under our care in which we failed to take blood pressure, urine, etc., is self-evident, and requires no discussion. The next most frequent mistake was in allowing these patients to continue too long after a diagnosis had been made. Bearing in mind that each case is an individual problem, and should be treated as such, we can still lay down a few general rules. If detected in early stages, diet, especially low salt elimination, and rest will usually check the progress, and if blood pressure reaches 150 systolic and progressive rise in diastolic I think absolute bed rest essential. If in spite of this and other routine treatment, blood pressure and other signs of toxemia increase (a good laboratory where possible being a great help) we feel that pregnancy should be interrupted immediately. You have nothing to gain by waiting, and everything to lose. Even if the patient does not reach the explosive stage of convulsions, apoplexy, or separation of placenta, damage is being done to the kidneys and other organs daily.

The patient then becomes a nephritic, cardiac or hypertensive case. This will make her a poor risk for future pregnancies, and shorten her

*Read before the Sixty-second Annual Meeting of the Florida Medical Association, Ocala, May 13-15, 1935.

natural span of life. Furthermore, each day that a toxic mother carries a baby decreases the chances of that baby being born alive, or living long after birth. Don't wait for her to reach term or to go into labor spontaneously. Act at a time when some good can be accomplished. A premature is better than a dead or extremely toxic baby.

Now as to treatment of patients in convulsions or coma, or both, *do not* do Cesarean section for eclampsia alone. It has been universally accepted as a proven fact that radical measures increase the mortality. The routine conservative treatment, while differing in detail in various clinics, follow the general lines of sedation, elimination, dehydration, glucose therapy and magnesium sulphate intravenously. This can be found in any standard text book. I wish only to caution against too generous and too frequent dosage of morphine. This is bad for mother and baby. I have had many patients admitted deeply narcotized, respiration six a minute, pulmonary-edema, etc. In the acute stage treat the toxemia, forget the pregnancy. As the patient improves back to pre-eclamptic stage, consider the case obstetrically.

We will group under one heading the various hemorrhages of pregnancy-abortions, placenta praevia, separation placenta and post partum. The cardinal point as to treatment in all these cases should be to conserve blood. Control bleeding as rapidly as possible and replace by fluids and transfusion. In all too many cases this point was not sufficiently stressed and accounted for a great many fatalities or near fatalities. In abortions many cases were allowed to bleed over a period of several weeks, then brought into hospital in an exsanguinated condition, immediately given anesthetic and curetted, frequently going into shock or later becoming septic. Bring them to hospital earlier if possible, transfuse before operation.

The large majority will not need an operation, as nature and time will frequently empty the uterus. Conservative treatment, such as bed rest, ice bags, oxytocics, careful removal of fragments from cervix, or tight cervical packing often suffices. We feel the primary indications for dilation and curettement is severe hemorrhage. We have seen several cases of punctured uteri from curettement. Curettage is easy from the surgeon's angle, but can have many bad consequences for the patient, such as future sterility, miscarriage and placenta praevia or separation. In frankly septic abortions do not invade the uterus at any cost until the temperature has subsided, except as a life-saver from hemorrhage. Treat conservatively, then operate later if necessary. This is generally accepted.

We cannot prevent placenta praevia, or entirely prevent mortality from this dreaded catastrophe. But we can recognize it early, and not delay action. Send the patient to the hospital if possible, make preparation for transfusion to be given before, during, or after delivery as needed. If these services are not available, employ a tight cervical and vaginal tamponade, a Braxton-Hicks version, morphine, etc. Whatever we do, we must never deliver a baby forcibly through an undilated cervix with the misguided intention of saving the baby. If so, we are liable to lose both mother and baby. The lower uterine segment has very little contractile power and the bleeding from laceration through the site of placental attachment is profuse before and after delivery. If cases can be hospitalized, probably the best treatment is Cesarean section, particularly with closed or only slightly dilated or effaced cervix.

One of the most frequent causes of premature separation of placenta is toxemia. Reduce the frequency of this condition, and we reduce the occurrence of separation. Our chief faults in these cases were the same as in so many other groups, lack of early diagnosis and procrastination in treatment. The typical signs in the concealed type are increasing pulse rate, abdominal pains, enlargement and tenseness over uterus, frequently absence of fetal heart sounds and movements, and signs of shock, and history. Cesarean section is usually most effective treatment. In these cases with evident vaginal hemorrhage and clots, treatment depends of course on severity of bleeding, patient's general condition, stage and progress of labor, and condition of cervix if not in labor. In other words, we must use our judgment as to whether we think patient can be delivered through regular passages before the loss of a dangerous amount of blood, either normally, forceps or version. If not, section. Be prepared for transfusion, and treatment for shock.

Some of the things that predispose to post partum hemorrhage are multiparity, hydramnios, twins or more, prolonged labor, exhaustion of patient, fibroids, too much anesthesia, operative deliveries with associated lacerations. Last and

most important is too early and too vigorous attempts to deliver placenta. Do not attempt to separate placenta by early massage of uterus. Do not attempt to express placenta by force or by traction or cord. These efforts might cause only partial separation with free bleeding before placenta can be completely expelled. We can prevent exhaustion of mother in labor by free administration of fluids and nourishment, and by giving plenty of rest by use of the many narcotics, hypnotics and analgesics on the market. We must recognize the various forms of dystocia and aid delivery at proper time. We must not do a forcible delivery in normal labor just to save time by version or forceps through an incompletely dilated cervix, or by pituitrin, minimum anesthetic. Avoid trauma as far as possible in delivery by more frequent use of episiotomy. Repair all lacerations as soon as possible. The treatment of post partum hemorrhage is in all text books. One little point to remember is intravenous use of pituitrin about 3 minims, if other methods fail.

The next large group we wish to discuss is Cesarean section. In practically all of the surveys made in this country as to cause of maternal mortality, indiscriminate and increasing use of Cesarean section has been given as one of the main reasons for continued high mortality. As surgical technic and knowledge of asepsis increased, the incidence of sections kept pace, until in certain clinics or among certain individuals, the only indication has been a pregnant woman and the surgeon's ability to operate. In the cases studied, we found most mortality was from poor obstetric judgment, or in operating at wrong time. A small number could be attributed to lack of sufficient surgical skill of operator. A large group was composed of operation for eclampsia. The mortality was 46%. As mentioned above, statistics universally show this to be the poorest treatment for the great majority of eclamptics. There were several cases where sections were done with dead fetus, or excessively small fetus, deformed fetus with no maternal indication. We consider this inexcusable. X-ray would have been of help here.

Another group with high mortality was composed of cases operated upon after prolonged labor with repeated examinations and attempts at delivery, with membranes ruptured for hours. Most frequently in these cases the baby is already injured by the long labor or trauma, the mother potentially infected, exhausted and a poor surgical risk. It is true that the low cervical gives better results than the old classical section in this type of case, but we think the risk is too great. All too frequently both mother and baby die. We feel it better judgment not to operate in these cases.

Many sections were done for occiput posterior alone, slow labor from inertia, slow cervical dilatation, etc. We believe most of these cases can be handled successfully along orthodox obstetric lines. We found that many cases that had difficult forceps or versions with loss of baby and injury to mother should have been sectioned early, and that cases that were sectioned should have had elective sections or not sectioned at all. In other words, this was poor selection and poor timing. There was lack of diagnosis as to cause of dystocia, lack of judgment as to best procedure to follow, and all too frequently the physician solved the dilemma by taking the shortest and easiest way—that of the knife.

We feel that there should be consultations before every Cesarean section and that we must consider not only the immediate outcome of this particular labor, but also her future obstetric history. Besides an immediate average national mortality of 10%—13% in Jacksonville—a very high percentage of cases remain sterile either in fact or from fear of future pregnancies. There is also the possibility of ruptured uterus in future pregnancy. Also remember the average fetal mortality in section is from 6% to 10%, and the excuse often given is the safety of the baby.

While in this particular hospital there were no maternal deaths attributed to sepsis, there were many cases evidencing milder types of post partum infection. But throughout the country as a whole this still heads the mortality lists. Why? How much of this can justly be placed at our doors? Most of it! There are a few elemental precautions that we all know and could take, but somehow overlook in our haste necessitated by a busy general practice. A large majority of deliveries are normal and easy, and if not ever-watchful we grow less cautious or even careless, assuming that all cases will be so, and therefore fail to give them the time and care needed. We break our technic when tired or in a hurry or for no reason at all, nothing happens, then we do so more and more frequently. We hope we will be pardoned for mentioning such elemental but essential points as: (1) warning your patients

against douches and intercourse during last month of pregnancy; (2) shaving the patient; (3) not making any more vaginal examinations than necessary, and always doing so carefully and with sterile gloved hand; (4) be doubly careful of your asepsis in third stage and when doing perineal repair; (5) never invade uterus after delivery except for most urgent reasons; (6) conserve patient's strength and conserve blood—a weakened anemic person being much more liable to infection; (7) wear a mask over nose and throat. It has been repeatedly shown that endemics of sepsis have been caused by spray from nose and throat of attendants. This is obligatory for all persons in delivery rooms at this institution.

Another heading under which I found many of our liabilities and casualties was dystocia from various causes. There was a case of ruptured uterus from pituitrin, quite a few cases of shock from brutal and unskilled version and forceps. But in this group, naturally the higher mortality was among the babies. In a paper of this type I cannot discuss in detail all the dystocias, their causes, treatment and prevention, but can only broadly mention our most frequent troubles. Many fetal lives were lost by injudicious or untimely operative deliveries—forceps or versions. Injudicious in that in many cases of disproportion, after fruitless hours of hard labor, a baby was finally dragged out of the pelvis by brute force. Proper antenatal measurements and prenatal examinations would have revealed an indication for an elective section. Untimely in that many cases were delivered either too early or too late. Frequently when in a hurry or when bedeviled by patient and her relatives to "do something, doctor," forceps were applied to an unmoulded, undescended head without having exact knowledge of position, which was then pulled forcibly and often unskillfully through a partially dilated rigid cervix. This was often fatal to baby and resulted in much damage to mother. Gentlemen, we all knew better before we ever graduated from school, or we probably never would have been graduated. Many babies were lost or suffered injury from being delivered too late; in many cases the mother struggled for hours in second stage with no progress, maybe slight disproportion at outlet malposition, secondary inertia, cord shortened or about neck, and other causes. We think the two-hour limit in primiparas in second stage a good rule, earlier in multiparas or at signs of fetal distress. Frequent auscultation of fetal heart will give us timely warning for the application of forceps, version or episiotomy alone. Many babies will thus be saved. But this requires the attendance of physician. We cannot sit in our offices or busy ourselves with house calls when a patient is in active labor—especially the second stage—only to rush out just in time to referee at delivery of the head which the nurse has probably been holding back against our arrival; skillfully cut and tie the cord; spank the baby, and then pridefully tell the anxious parents what a fine baby we found for them. In these cases, nature, mother and nurse could do everything we do. But if labor is abnormal, or if there are signs of threatened fetal asphyxia, we must be on the spot to recognize and act while there is still time. I realize that in a busy general practice, with all types of patients making demands for your services and presence, it is hard to give up the required time to a woman in labor, often in wee small hours of the night and with little or no remuneration. Nevertheless, it is essential if we wish to lower our death rate.

Pituitrin naturally is not used as frequently in hospital as in the home, so in this survey there were not many liabilities. There was one case of ruptured uterus with death. A few cases of cerebral hemorrhage in new born. But why is it used so frequently in homes? In hospitals patients are watched by nurses, and physician called for delivery. The physician does not often have this service in home confinements, and he feels that he does not have the time to spend with patient himself, so he hastens it along with pituitrin. If labor is progressing normally, it is needless and unphysiological. If uterine contractions are too weak, and conditions for delivery are present, proper application of forceps is safer. If because of disproportion, rigid cervix, malposition, etc., pituitrin is doubly dangerous. There is a better procedure for each of these complications. I know I will have the support of the pediatricians and neurologists when I plead for the most cautious and sparing use of pituitrin before the delivery of baby.

Prematurity takes a large toll of fetal lives. The various toxemias, infections, syphilis, overwork, and general debility, account for the greatest number. Timely and adequate prenatal care should prevent many of these. Remove foci of infection, reduce the toxemias, give active specific

treatment to mother during pregnancy, improve general health as indicated. Give advice as to proper rest and things to avoid, as long automobile trips, stairs, heavy lifting, overwork in general. The treatment of prematures is a science in itself, and we leave that to the pediatricians to discuss.

Gentlemen, I hope that this discussion has not seemed too elementary or too judicial. It was intended to be just observations based on a review of about 2,000 unselected cases, my own included. It was not just fault-finding, but fact-finding with the purpose and hope of correcting our mistakes and improving our results. Let us always remember that we have two lives at stake, give our patients more of our time and the benefit of our training. Call on our brother physician more often in times of distress. Consultation is beneficial to both the patient and ourselves. We will be amply repaid, if not in money, at least in the self satisfaction of a job well done and a trust well kept. Thank you.

DISCUSSION

Dr. C. J. Collins, Orlando:

I think Dr. Norris has made us feel very keenly this morning the responsibility of the doctor in the high maternal and fetal mortality. Every doctor who does obstetrics has to have a great amount of patience and obstetrical conscience. How many of you have been tempted to dilate a cervix and apply high forceps, then received an emergency call, and on returning found the baby's head on the perineum?

There are at least 25,000 women who die in this country each year from childbirth. There are about 100,000 babies who die at birth and another 100,000 who die the first year after birth Only tuberculosis kills more women in this country today during the childbearing years. In reviewing the statistics on maternal mortality we find that at least 50% of these women who die as the result of pregnancy, die from sepsis, post abortional and postpartum. This is preventable in a great majority of cases: 1, by eliminating vaginal examinations during labor: 2, by conserving the patient's strength during the second stage; 3, by conservation of the loss of blood during the third stage of labor. Twenty-five per cent of these women die from toxemia. Deaths from toxemia are also preventable in a great majority of cases, by proper prenatal care, by induction of labor before the onset of eclampsia, and by treating eclampsia conservatively as a medical disease. Fifteen per cent will die from hemorrhage, ectopic pregnancies, postpartum, placenta praevia and accidental separation of placenta. Here our great hope for reducing mortality is in not delaying too long with these patients in the hope that the hemorrhage will stop spontaneously. There are about 7% who will die from heart disease, tuberculosis, and diabetes. These deaths can also be reduced by proper cooperation with the internist during pregnancy, by conserving the strength of the patient during the second stage of labor and also by the judicious use of forceps and Cesarean section. Three per cent die from some complication such as pneumonia or pulmonary embolism. There is not a great deal we can do in reducing our mortality rate in this class. We can say that at least two-thirds of these deaths that occur during pregnancy are preventable.

I thank Dr. Norris very much for his excellent and timely paper.

Dr. H. D. Smith, Sanford:

I would like to say just a few words to add to what Dr. Norris has said.

I know of no greater liability for any physician to assume than in the practice of obstetrics. We all realize that we have fallen short of our goal of trying to leave our patients in as good physical condition after giving birth to a child as she was prior to conception. This goal may never be attained but we can go a long way toward it by proper handling, pre-natal, natal and post-natal care.

Now, I believe that the great trend in obstetrics today is to deliver the baby with patient knowing but very little about it. I am fully confident that a large number of deaths is due to the improper use of analgesia and anesthesia and I mean improper use, too early use of analgesia or anesthesia in the early stage of labor and in uterine inertia or cases on the border line of uterine inertia. I believe that if we will let our patient take her time, not consider the length of time, that ordinarily we would not make this mistake. The woman naturally would like to have something to relieve the pain and we try to make her as comfortable as possible, but I think that has a great deal to do with our post-partum hemorrhages and possibly the asphyxiation of our babies by too much use of analgesia and anesthesia. Of course we could use larger amounts of anes-

thetics and make childbirth undoubtedly more comfortable to the mother. I believe that each case should be studied separately and worked out according to that particular case.

Any over-stimulation of uterine contraction produces many times relaxation to follow, and post-partum hemorrhage. Every one who has done obstetrics has seen this condition.

We know another thing, that our liability in regard to muscle exercises following childbirth is quite a responsibility. Practically 75% of mothers have some trouble following childbirth. And usually there is some peeling off of cervical tissue. We should give our patients the proper post-natal care to produce the proper uterine contraction and involution and bring that uterus down to a normal position. It should take about four to twelve weeks. Keep her in bed the proper length of time and give ergot three or four times a day for four days following the birth of the baby. Make sure of the proper uterine contraction and involution before discharging the patient. Have her report back for examination within four to six weeks or after lochia has ceased. All eroded areas should be touched up to give her a normal cervix. There is where our danger comes in, carcinoma, as we all know.

I feel, also, that exercises following childbirth have a great deal to do with the physical condition of mothers. Give them the proper exercises to regain the proper size and position of the uterus following childbirth, put it back in normal position. Sometimes it is necessary to wear a pessary a few days or months. Have her take exercises after four or five days, turn over and lie across a large pillow 10 minutes night and morning. Give knee-chest position after lochia has ceased and various other exercises that you all know. They will do a great deal to strengthen the uterine contractions and the structures of support of the uterus.

Don't have these women complaining that they have felt bad ever since giving birth to the baby, possibly from non-uterine contractions, improper position or a sub-involution.

I hope that we will all be stimulated by this paper and will give our obstetric patients more consideration and more attention than we have in the past.

Dr. R. G. Nelson, Tampa:

I would have to rise and discuss this paper if only to compliment Dr. Norris. A paper like this certainly cannot go unrecognized. A man who has reviewed two thousand cases and worked out to determine the cause of death and where we have fallen down and then brought this message to the profession showing that two-thirds of all maternal deaths are preventable—is an authority on this subject. Certainly nothing else could so stimulate a man to go out and preach the gospel. If you are not qualified to do obstetrics have the guts to refuse to take them.

Two-thirds of all maternal deaths, Dr. Norris has said, are preventable. I think every man connected with a hospital organized staff would do well to follow his example. Take your service from the hospital files, and review it, analyze what has existed or where the mistakes are.

After this message today we certainly cannot go out and face the layman and say that we are letting 25,000 mothers die each year and two-thirds are preventable. At least to my mind he has brought a message that ought to spur us along. I certainly want to congratulate him again.

Dr. S. R. Norris, Jacksonville (concluding):

I have nothing further to say. I selected this subject because it is non-controversial. I do not want to try to prove anything. When this work was started it was really to find out what was being done in that particular hospital. So there is nothing further to say except to thank the men for their generous discussions.

THE NERVOUS BREAKDOWN*

H. Mason Smith, M.D.,
Tampa.

It requires the command of considerable courage to discuss before this Association a topic to which I will probably add nothing new or original. The subject of psychoneurosis has been extensively covered in the literature, and when a writer expresses a thought which is probably original with himself, he invariably, if he pursues literature further, finds that the same thought has been expressed many times before.

However, it is felt that justification for this paper is found in the importance of the subject and the extensiveness of psychogenic conditions which have been becoming of such vast general interest that the magazine "Fortune" in the April issue presents the views of a dozen leading

*Read before the Chattahoochee Valley Medical Assn., Radium Springs, Ga., July 9th, 1935.

psychiatrists of the world on the subject in such terms that a lay reader can fully understand and comprehend the neuroses.

The amazing statistics produced in this article is that half of the hospital beds in the United States are occupied by mental patients of which there are 500,000 in mental hospitals and 525,000 in other hospitals: also that during the last 50 years, while the population of the United States has little more than doubled, admissions to the State Hospitals have increased ninefold. According to some British statisticians, if the rate increase continues, there will not be a vestige of sanity left by the year 2031.

This apparently makes this condition the greatest challenge to medicine, but a still greater challenge than the psychoses are the psychoneuroses. We have no way of obtaining statistics on psychoneuroses, as the majority of neurotics do not go into hospitals and case histories are not available.

I have chosen for the title of this paper a most elastic term which includes in the minds of the layman every condition from the most severe organic psychosis, such as paresis, to the case of fatigue due to hard work or mere boredom from lack of work. For the purpose of this paper, the subject will be confined to psychoneuroses with special emphasis on anxiety states.

In the introduction we should have clearly in our minds the difference in psychosis and psychoneurosis. Psychosis is insanity, of course, with a loss of personality. The people affected live in a world of fantasy and are not subject to the general physical laws, while the psychoneuroses are the result of a conflict between the conscious and the unconscious forces of the mind and, therefore, only part of the personality is affected. As Dr. Franz has written, "the psychoneurosis represent the battle on the inside of the patient where the primitive forces of the unconscious are clashing with the inhibitory forces of the conscious mind. The psychoses represent the complete victory of the primitive forces over the conscious mind with disintegration of the personality."

The psychoneuroses are not considered sufficiently serious by the average medical men, many of whom assume that it is a condition to be controlled by the patient himself, which causes his attitude towards the patient to be unsympathetic and his prescriptions to the patient are usually such terms as, "Snap out of it, it is purely imagination"; "Get to work, forget yourself". The psychoneuroses are a major disability, they not only cut off a person's ability to earn a living for himself but cut off his friends, his happiness and his activities in society and cause him to lead a life of isolation and despair.

Classification

The classification of the psychoneuroses into the hysterical type, neurasthenic type, psychasthenic type and anxiety states, has met with general agreement and approval the world over. This classification, however, is arrived at by symptom complexes and the types are not separated by hard and fixed lines. A psychoneurosis of any type may have the symptoms of all the others but is classified by the preponderance of the symptoms.

The hysterical type is the most variant in its manifestations, the most dramatic, the most spectacular and the most episodic of the group. The variance of the symptoms of the hysteric is of such a wide range as to assimilate any organic disease known and is so extensive that only a brief outline can be given. The most common are motor and sensory disturbances which are expressed by paralysis, paresthesias, anesthesias, hyperasthesias, convulsions, cataleptic or trance-like states, contractures, tics, and choreiform movements. There are aphonia and blindness; then there are other conditions as displayed by amnesia, double personality, stupor and other disturbances of consciousness.

The unconscious motive or craving is more superficial in hysteria than the other types. Therefore, the motive is more easily discernible. A hysterical subject is more inclined to cherish his illness and most reluctant to give it up until the unconscious craving is satisfied.

Report of Case

Mrs. E. K., Age 43, Widow, Occupation: Companion. While taking a meal in the dining car of a train the coupling between the cars broke, which gave her quite a jar.

Soon afterwards her back began hurting in the lumbar region. This pain gradually moved upward until she had a pressure sensation with drawing backwards in the occiput. The condition got worse until she finally consulted a surgeon who did x-rays and advised her that there was no injury done by the jar, that it was a functional nervous thing, but on her learning that he was

a railroad surgeon, both the pain and the spasm got worse. She was unable to take a deep breath, could not drive a car, had painful areas all over the back. The osteopaths and chiropractors had informed her that she had torn ligaments and leaders. She was emotional, restless, exhausted, dizzy and unable to concentrate.

Physical examination was negative. It was brought out that she was tired of being a companion to cranky old people, that she could purchase a little home and live with her son if she had a little more money and when shown that the craving for a nice verdict was at the bottom of her physical condition, she refused to accept it from the examiner, but has written him many letters to the effect that nervousness would not cause so much pain, and that he did not understand her condition.

The symptom complex of neurasthenia is centered around fatigue and exhaustion. There is a physical exhaustion with what at times is termed the "effort syndrome," mental exhaustion with inability to concentrate, read or think consecutively. There is mild depression, discouragement, inferiority complex, sometimes fears and anxiety. Aches and pains are always present. There are headaches characterized by band-like pressure, or pressure at the base of the brain. There is a profound intraversion, loss of interest in everything but one's self or one's organs.

The psychasthenic type is characterized by obsessions, phobias, and there are many kinds of phobias, doubts, inability to make decisions even on trivial matters. Just as a physical symptom is symbolic of an underlying conflict in hysteria, so an obsession is a substitute of a deeply buried desire, probably sexual, in psychasthenia. The desire is buried deeply in the unconscious in psychasthenia and more difficult to bring to conscious or to the surface, causing this type of psychoneurosis to be most difficult to treat.

In anxiety states, fear and intense anxiety are constant and these are often associated with cardiac, respiratory, gastro-intestinal and vasomotor disorders. The anxiety states are the last to have been studied and classified. They are termed the "modern neurosis," and are more common in modern times.

A comprehensive discussion of the etiological factors of psychoneurosis is beyond the scope of this paper, but I shall endeavor to give briefly the summary of the present conceptions of the etiology.

Etiology

The studies of Charcot and his contributions on the subject of hysteria were really the beginning of the modern approach to the study of psychoneuroses. Bernheim of Nancing later discovered the influence of suggestion in the productivity of psychoneuroses and elaborated on hypnotism as a treatment. In the beginning of this century, Janet of Paris did some brilliant and illuminating work in psychology. Janet advanced the theory that due to a poor synthesias of the personality certain groups of ideas were dropped off from effective or harmonious association with the main portion of the personality and exist independently in the subconscious. He thought hysterical symptoms were manifestations of these "split off" parts of the personality.

Up to this point the literature on the subject had been purely descriptive and it remained for Sigmond Freud to answer the question as to why or to make explanations as to the cause of these conditions. It was Freud's idea, and he was really the first man to explore the depths of the unconscious mind, that the mental forces which arise in the unconscious, most of which have an infantile sexual connection, and which were not acceptable to the consciousness of the individual, were the productive of psychoneuroses. The symptoms were compromises and symbols of these mental conflicts. In the same way he considered the unconscious mind a reservoir for past experiences which were striving for a place in the conscious mind but because they were not acceptable were constantly repressed and came through as nervous symptoms.

Dejerine entertained the opinion that the psychoneuroses were of mental origin and that the emotional content of the mind was mishandled by incorrect thinking and mental attitude. White, while accepting the above theories, pointed out that there is a loosely organized personality in hysterical patients with a faulty synthesis which causes the personality to be more susceptible to the destructive influence of disordered mental processes. Adler produced the theory of constitutional inferiorities.

The great Russian physiologist, Pavlov, interpreted both normal behavior and the manifestation of neuroses in the terms of conditioned reflexes. Pavlov established the principle of conditioned reflexes which is understood to be a

physiological response to a secondary stimulus that is not primarily capable of bringing about that particular response. Thus the presentation of food to animals causing a flow of gastric secretion is a primary stimulus with reflex response. The association of a sound, like a bell, with the feeding is a secondary stimulus which ultimately results in a flow of gastric secretion even though no food is presented, is a secondary or conditioned reflex.

The preparation of going to bed at night, such as undressing and the final recumbent position with complete relaxation brings about sleep which is a condition reflex, unless this reflex is frustrated by inhibition on the part of the individual. Pavlov, by frustrating conditioned reflexes, produced a condition of demoralization in dogs which bore resemblance to the psychoneuroses in man. While conditioned reflexes have not been accorded the prominence of influencing behavior to the point of causing psychoneuroses, they are certainly a factor in the well-being of man.

There has been considered as causative many other factors, among which are foci of infection and autointoxication. It seems very difficult for the average medical man or surgeon to conceive of a symptom complex so severe as some cases of psychoneuroses existing without a pathological basis. In fact many psychiatrists have attributed constitutional weakness, hypersensitivity of autonomic nervous system and endocrine disorders as etiological factors. All of these factors may be and some are contributory, except the disorder of the autonomic nervous system and the endocrine imbalance. There has never been any definite determination whether these were causitive or resulting from psychoneuroses. When one is burdened by internal conflicts, by suppression and psychic traumata, he may be able to carry the burden and make necessary adjustments until the nervous threshold is lowered by intoxication or other stresses and then the burden becomes unbearable and the break occurs, adjustments fail.

It was Freud's idea that anxiety states were caused by sexual frustration but all other psychiatrists are in agreement that there are other causes, such as: conscious problems sometimes causing conflicts, not between consciousness and unconsciousness but conflicts entirely in the thinking mind that bring about anxiety and worries which are contributory to neuroses. The man who is working against odds to prevent business failure, the Catholic working woman who finds herself pregnant and sees no escape yet the birth of the child will cut off livelihood, are examples of what may precipitate an anxiety state.

In this connection we see people who go through life in a state of anxious expectation, to whom there is very little freedom from anxiety and no relaxation, people who have fallen in the habit of making life hard for themselves. When in business they worry all night about the sales of the following day and the events of the preceding day. They worry about operation expenses, about their health, about their children and contemplate all the gloomy possibilities that may occur.

In this strenuous and competitive age, there are many mothers who continually express anxiety about the school work of their children, their social position and health and thereby lay the pattern which is copied in behavior by their children. This anxious anticipation not only contributes to nervous unrest but to vascular disease and results either in an anxiety neuroses or coronary thrombosis.

It is the concensus of opinion with psychiatrists that psychoneuroses are mental in origin and one need not look outside of the mental processes for causes except, of course, contributory or precipitating causes. There is no doubt but that many organic conditions are brought about by the disordered mental processes such as conflicts and anxiety states. Alvarez attributes many gastric ulcers to psychogenic origin. The anxiety causes hyperchloridia which in turn makes destructive inroads on the gastric mucosa. Those of you who have read his book "Nervous Indigestion" can appreciate the frequency of gastric symptoms from mental causes.

Treatment

Since the etiology of psychoneuroses is primarily mental and arises from disorders of the mental processes, the logical treatment is psychotherapy which consists in penetrating the mind and correcting these disordered mental mechanisms.

A mental analysis is necessary in practically all cases. This does not mean that an orthodox or Freudian psychoanalysis has to be made in which dreams are interpreted and associations considered which requires an hour a day for a year or more. The time and expense makes it

impossible for all except a few "well-to-do" from entering into a treatment of such magnitude. Beside people over fifty, and many other patients are not benefited by a Freudian psychoanalysis. After the mental processes have followed a certain pathway so long, the course cannot be changed easily, even by going back to the spring head. The limitations to this method are such that the average psychiatrist adopts a modified technique which is usually effective.

It is impossible, however, for the vast majority of psychoneurotics to get to a psychiatrist. Any physician with an insight into human nature may get a better understanding of his patient by most confidentially learning of his innermost problems and sympathetically assisting the patient in handling them consciously and in that way relieve the emotional stresses that cause so much discomfort and symptomotology. Probably the best method of obtaining their confidence is to listen to the story informally and with interest. A complete history is essential. This should not only include past illness but details especially emotional experiences, family influences, childhood, adolescence, marriage, social relations, personality development, sexual implications, economic failures and successes.

A more complete physical examination is required in these cases than in organic diseases, this not only to search carefully for any pathology, the correction of which will aid in the treatment, but to be in a position to state authoritatively that the condition is functional which would be difficult for the patient to accept without such a study. By this the patient's confidence is obtained which is imperative in the successful management of nervous cases.

Medicines in psychoneuroses are of practically no value except for the suggestion that is conveyed with them. No case of compulsion neuroses has ever been cured by cacodylate of soda or any other injection except possibly through the suggestion that this therapy conveys. Suggestion is the most powerful instrument by which these people are treated and any physician is entitled to use it in the most effectual and reasonable way for the benefit of his patients whether it is by giving an injection, actinic rays, or massage. It may be dangerous, however, to attach the cause entirely to a focal infection which when removed leaves the neuroses with all its agonizing symptoms.

In glandular therapy there is an opportunity for a great deal to be accomplished as there is in most all psychoneurotic states a glandular imbalance; whether this is the cause or the result has never been determined. When the faulty acting gland is found, whether it is the pituitary, the thyroid or the adrenals or ovaries, treatment accordingly is beneficial.

It is necessary, of course, to assist as far as possible in the adjustment of the individual and even if the physician's efforts in this line are not 100% efficient, there is a great deal of hope that the patient will in time be able to handle his conflicts and make adjustment. This may not apply in hysteria that is so strongly motivated for compensation or gain. In this the forces of the ego or the unconscious are defended consciously and the individual resists all efforts of the physician to make him see the origin and cause of the symptoms. These cases, of course, clear up when the motive is satisfied or found impossible to gratify.

Much can be accomplished in the prevention and treatment of anxiety neurosis by the patient adopting the philosophy of nonresistance, as proclaimed by Anna Payson Call in her book "The Freedom of Life." If we can persuade the patient to relax and permit the forces of nature to operate—to accept the result of natural forces, and not resist them by "tightening up" we can prevent anxiety states as well as much of the vascular disease. To do this one must assume the characteristics of a wet dish rag. One must cultivate the faculty of being knocked down by a feather. We must develop the ability to live in the present, without anxious anticipation, and allow the conditioned reflexes of Pavlov to operate.

In the majority of psychoneuroses and in all anxiety neuroses there is a morbid fear of insanity. These conditions do not often merge into psychosis. The assurance of this often brings intense relief to patients.

Many adolescents are the victims of anxiety states because they have been guilty of masturbation, which has been erroneously and generally thought to be a cause of insanity. Masturbation has never caused a mental breakdown, and when done excessively is the result of a psychotic state rather than the cause. Worry about it, however, will precipitate a psychosis, and every physician should protect his youthful patients with this knowledge.

The majority of the conditions faced by all

medical men are functional or of psychogenic origin. With this condition it is logical that the major preparation of physicians should be in the psychological and psychiatric field. This would surely be the most effective weapon against the various cults and charlatans. It is tragical that so many learned physicians can not see any condition unless it is confirmed in a test tube. His results with the psychoneurotics, as compared with Christian Science reader or even a chiropractor are profound reflexions of that tragedy.

ORGANIZED LABOR AND RAILWAY MEDICINE*

V. A. Lockwood, M.D.,
St. Augustine.

Railways undoubtedly offer the safest means of travel that we have in spite of the glaring defect that we will discuss today. The public has been impressed with the elaborate means of protection, in regard to mechanical and engineering safeguards, that have been provided. At considerable expense, equipment is frequently inspected—the locomotives, the cars, the air brakes, the signals, the switches, the rails.

But do the railways take similar precautions with the employees that operate the trains? A questionnaire taken a few years ago revealed that none of the thirteen railways comprising the southeastern district required a periodic examination of their train service employees. Here is a link in the safety chain as important as the mechanical. Certainly the engineer's acuity of vision is as essential as the signal system, while failure of his heart can be as disastrous as a failure of the air-brakes. Why, then, is the human element disregarded, insofar as health examinations are concerned? The railway medical staffs are already established and the additional cost would be meagre. But because of the attitude of organized labor this issue has not been forced to the detriment of all parties concerned: the railway, by damage to equipment and liability claims should wrecks occur; the traveling public by endangering its safety; the employee by denying him the benefits of periodic health examinations.

Because of the political influence of a large labor group, little can be expected of any governmental regulating commission toward effecting such requirement, even though stringent rules may necessitate the provision and inspection of all sorts of mechanical safeguards.

In what way then can we keep these employees under medical observation and how can the situation be improved? First, by the careful selection of candidates for employment. In accepting applicants the examiner should look ahead twenty years. The man with the well compensated heart murmur, with the moderate rise in blood pressure, or with the history of arthritic symptoms may be well along the road toward disability within fifteen or twenty years. Why take on today those which will cause us grief tomorrow?

Secondly, check-up examinations are made under the rules for various reasons: if an employee has been out of service for six months; following recovery from a severe illness or injury; for promotion; for pension; and if, in the opinion of a superior officer, examination is advisable when some physical defect is apparent or the employee fails to observe signals or perform his work properly. Defective employees once found should be kept under observation.

Finally, the Hospital Association with its staff of local surgeons perform a most important function in detecting and treating the physical ailments of employees. Upon this organization falls the tremendous responsibility of seeing that the men who run the trains are mentally and physically capable, and that catastrophe will not occur through the sudden failure of the human machine.

Sometimes I like to compare our medical offices with automobile service stations. These latter give what they call service plus. When the motorist drives in for gas they check the oil, the water, the tires and even the brakes and motor if time is afforded. The motorist leaves with a sense of security, a valuable machine is protected, and accidents are less liable to happen. Perhaps the station attendant hasn't had in mind the extent of the scope of his work, but he does make additional sales. Why can't the doctor render the same service plus? I am sure that many of us do. When a man comes for a trivial ailment why not observe him carefully? Is his hearing acute? Has he had his blood pressure taken recently? If we apply this rule to our train service employees the man will frequently be benefited by the detection of some serious disease and helped by early treatment. The railway and the traveling public will likewise be pro-

*Read before the Sixteenth Annual Meeting of the Florida Railway Surgeons' Assn., Ocala, May 13, 1935.

tected, while the doctor himself increases his practice.

This program cannot be successfully carried out unless the confidence of the labor organizations is gained; by always dealing squarely with their members; and by manifesting a helpful interest in their physical condition. We should not strive to seek out those men who are not perfect specimens of manhood and discharge them from employment. Rather do we desire to detect disease in its earliest stage and to keep them on the job as long as possible by assisting in the maintenance of health. Never should a long record of service be forgotten, and I have found that almost invariably a man can be placed in a less dangerous position if he is at all able to work. An engineer seems willing to give up a crack passenger run and to work on a branch line or a switch engine or to hostle if he knows that through some serious physical defect he endangers the lives of those whose safety is entrusted to his care.

It has been my experience that railways wish to maintain their old, trusted and valued employees in service as long as possible and will bend their efforts in this direction as far as compatible with safety. That policy would be shortsighted which eliminated the older employees unless a suitable pension be provided, and its effect upon the loyalty of the remaining employees would be disastrous.

The labor unions have always feared that examinations by medical departments of railways might be used as a subterfuge to eliminate undesirable employees. This is unfounded in my experience, as one such unfair action would tear asunder that trust and confidence that we are trying so hard to establish.

Such policy in our hands is producing results and we find more and more men reporting voluntarily for health examinations, coming now in confidence with nothing ailing them, when hitherto some had come in trepidation when ill. I am reminded in this connection of an experience in a steel corporation. My predecessor, as physician to this corporation told me that there was seldom a case of venereal disease among the several thousand employees and that the rule required elimination of the employee when such infection was detected. By adopting a sensible policy in helping the diseased individual to obtain treatment, and not causing him to lose time from work, dozens of such cases were soon under observation and the possibilities of dissemination of contagion lessened by giving proper instructions and treatment. We are faced with a similar situation when we endeavor to keep train service employees under medical observation. They will tend to report for examinations when they learn that their health is safeguarded and that their job will not be jeopardized. Safety of train operations is enhanced by a policy that brings to light most of the physical defects of the employees and by placing defective employees in less hazardous positions; and it is endangered by having most of these defects hidden when those employees are discharged outright. Placement of defectives and their medical correction are two services that represent a square deal to labor.

I hope that this message has conveyed to the Florida Railway Surgeons that the interests of the railway, the employees and the public are best served by the policy that has been outlined, and under it railway surgeons can in time bring under observation practically all train service employees with the assurance that passenger trains at least will be operated by men physically fit.

A COMPARISON OF DISEASE INCIDENCE IN IOWA AND FLORIDA WITH SPECIAL REFERENCE TO THE EFFECT OF CLIMATE UPON THE INCIDENCE OF DIGESTIVE DISEASE*

P. B. Welch, M.D.,
Miami.

This paper attempts to rationalize the differences in diagnosis in two series each of 1,000 consecutive cases seen in two widely separated localities by the same physician doing the same type of work, internal medicine, chiefly gastroenterology, in both localities. The first series of 1,000 cases was seen in Iowa. The second series was seen in Miami, Florida. There was a wide variation in the character of diseases seen in these two widely separated areas. Naturally, one would expect to find a lower incidence of infectious and contagious diseases in south Florida because of the climatic conditions encountered here. The effect of climate upon diseases of the respiratory system, the cardiovascular system and particularly upon certain types of infectious dis-

*Read before Dade County Medical Society, Miami, April, 1935.

eases such as acute rheumatic fever or rheumatic carditis has been investigated and reported upon by many workers, particularly Nichol[1] who has recently made a rather exhaustive survey of the literature as well as personal observations upon the effect of climate on the incidence of rheumatic carditis and respiratory infections.

In this series of 2,000 cases the diagnosis of respiratory, cardiac and infective diseases was largely incidental and usually associated with some gastro-intestinal disturbance. Even so, the incidence of occurrence of these diseases bears a striking similarity to the findings of other investigators.

The importance of the effect of climate upon the incidence of digestive diseases has probably not been properly appreciated. It is the purpose of this paper to emphasize the wide variation between the incidence of the diseases found in the digestive tract in the North and in this subtropical climate. It is believed that these variations are the direct or indirect result of the climatic environment of patients living in this area.

The incidence of diseases outside the digestive tract are listed in the Tables 1, 2, 3 and 4.

Table No. 1

Blood and Miscellaneous

	IOWA	FLORIDA
Anemia—Secondary, all degrees.	607	243
Anemia—Pernicious	12	3
Anemia—Chlorotic	3	0
Chorea	5	0
Arthritis—All types	50	31
Diabetes Mellitus	27	8

Anemia:

The incidence of secondary anemia is surprisingly low in this southeastern region being only 243 cases against 607 in the north. This wide variation is probably predicated on several different conditions, first, the high year-round ultra violet radiation, the correspondingly low incidence of bodily infections and the outdoor habits of living engendered by a twelve month outdoor season.

Among the primary anemias, pernicious anemia occurred twelve times in the north and only three times here in the south. The number of cases of pernicious anemia are too few to form an accurate basis of comparison of incidence.

Chlorosis apparently is a rare disease here. A visit to our beaches will perhaps offer a rational explanation of its absence.

Table No. 2

Respiratory Tract

	IOWA	FLORIDA
Sinusitis—All types	89	20
Diseased Tonsils—All types	466	253
Nasopharyngitis and Rhinitis—All types	194	186
Bronchitis—All types, non-tuberculous	50	12
Tuberculosis—Pulmonary	29	26
Pneumonia	3	0
Emphysema Pulmonary	34	13

Respiratory Disease:

The high incidence of sinusitis in the midwest is perhaps the outstanding feature, there being 89 cases against 20 cases in south Florida. Some of the south Florida cases were imported from various points in the north. In this series 22 ethmoidal cases occurred in the north against 13 here. This being a chronic degenerative disease the ratio of approximately 2 to 1 is not surprising. In the antral sinusitis, usually more or less acute, the ratio is 57 to 7, or approximately 8 in the north to 1 here. This probably represents a fair ratio of incidence of acute and subacute sinusitis.

Tonsils—The incidence of infected tonsils is about 2 to 1—466 to 253. This is probably explainable by the lower incidence of other upper respiratory infections in this equable insular climate.

Pulmonary Disease—There is no startling discrepancy between the incidence of pulmonary infection in the north and south except the expected lessened incidence of bronchitis and the rare occurrence of a true lobar pneumonia here. We have perhaps lost many prominent citizens by death due to pneumonia because they have returned to the unstable weather of a northern spring instead of remaining longer in the south; such an one was the late Chauncey Depew.

The incidence of pulmonary tuberculosis is approximately even in this series. The low altitude and relatively high humidity of a semitropical seashore are not particularly advantageous for the pulmonary tuberculide.

Table No. 3

Circulatory System

	IOWA	FLORIDA
Valvular heart disease—All types including active endocarditis	53	19
Pericarditis—Acute and chronic.	4	0
Myocarditis—All types	32	25

Arteriosclerosis	69	33
Arterial hypertension—All types	200	120
Arterial hypotension	84	26

Cardiovascular System:

The variation in disease incidence is rather wide with this southern area holding a very favorable position. It is perhaps well to discuss first some easily overlooked factors in this group. First, many cardiovascular cases are imported residents of this area, having been sent here from all over the north. Certainly there is a considerable number of elderly people retired from business and residing here permanently, striving to lengthen their life span, among whom normally there is a higher incidence of cardiovascular disease. In addition to these are numerous cases referred here from the north as tourists. The result should be a natural concentration of cardiovascular cases in this area. This condition does exist, but in spite of it the ratio still remains favorable for this area.

TABLE No. 4

Genito-urinary Tract

	IOWA	FLORIDA
Nephritis—All types	72	39
Ureteral Stricture	6	37
Ureteral Calculi	0	5
Nephrolithiasis	2	10
Pyonephrosis	0	4
Pyelitis—All types	22	51
Prostatitis—Acute and chronic	36	40

Genito-Urinary Tract:

Special reference to Table 4 is necessary.

The higher incidence of nephritis in the north, 72 to 39, bears approximately the same ratio as arteriosclerosis, 69 to 33, and suggests that degenerative diseases of the cardiovascular-renal systems is actually less likely to develop in this area.

The increased frequency of occurrence of the diagnosis of ureteral stricture might seem to be due to the fact that this condition had previously passed undiagnosed. This was not the case as the diagnostic importance of ureteral stricture as a source of abdominal pain and digestive symptoms was thoroughly understood and appreciated.

The large incidence of kidney and ureteral stones in Florida has been well rationalized by Holmes and Coplan, who found an incidence of calculosis in the urinary tracts of 29.88% of urological cases.[2] This high incidence of calculosis is quite logically explained largely upon the basis of habitual high alkaline ash diet with its concomitant low vitamin A content and high phosphates in an alkaline urine.

It is quite conceivable that the incidence of stones bears an etiologic relationship to strictures of the ureter.

TABLE No. 5

Digestive Tract

	IOWA	FLORIDA
Carcinoma	15	6
Esophageal	2	0
Gastric	8	4
Duodenal	2	0
Colon	0	1
Rectal	3	1
Gastric Ulcer	46	19
Duodenal Ulcer	44	20
Cholecystitis—All types	32	36
Cholelithiasis	8	11
Hepatitis (All forms)	41	7
Colitis—All types including unstable colon	191	64
Colon Stasis	306	311
Hemorrhoids	43	16
Appendicitis—Chronic	72	39

Gastro-Intestinal Tract:

At first glance it might seem improbable that climatic differences would have much influence upon the character and frequency of gastro-intestinal conditions. The occurrence of 191 cases of colitis (all types) in the north against 64 in Florida cannot be ignored. This wide variation, 3 to 1, is doubtless due to several factors incidental to climate: (1) The character of the average diet in this semitropic area is usually nonputrefactive and mildly laxative. (2) The relative freedom from concomitant bodily infections such as sinusitis, respiratory infections, tonsillar infections, etc. (3) The uniformly high incidence of ultra violet radiation twelve months in the year with a probably increase in diffusible blood calcium. (4) The equable and constant external air temperature, humidity and sea level pressure resulting in a very definite metabolic economy. Which of these conditions exerts the most influence is a matter for conjecture and further observation. Certainly colitis is not the omnipresent problem it is in the north but it would be less than the truth if admission was not made that there are here still a sufficient number of chronic intestinal invalids to keep one properly humble.

It is an interesting fact that the number of ulcers (gastric and duodenal) bear approximate-

ly the same ratio in the northern and southern group as colitis, approximately 2.5 to 1,—100 in the north to 41 in this area.

It has long been known that chronic appendicitis, gall-bladder disease and other abdominal visceral diseases produce reflex spasm of the pylorus. Carlson and Litt[3] pointed out that "motor disturbances of the pylorus may be induced . . . by excessive irritation of most, if not all, sensory nerves, particularly those of the abdominal viscera."

It was shown by the author in a previous publication[4] that not only was there reflex spasm of the pylorus but that there also existed a definite reflex spasm of the muscular activity of the stomach and a complete reversal of the normal muscular feeding reflex mechanism in the stomach associated with a variety of conditions including irritable or unstable colon.

If the assumption is justified that the formation of peptic ulcer is predicated upon trauma (spasm) plus infection, it would seem to indicate that the lowered incidence of colon pathology was at least partially responsible for the lowering of incidence of peptic ulcer, and that the low incidence of ulcer should be in part at least ascribed to the lowered instances of extraneous infective areas. (Respiratory Table 3).

One other factor exists that cannot be minimized—that is, the almost constant bombardment of the body in southern Florida with almost unfiltered ultraviolet radiation. Unquestionably this constant and abundant supply of radiation does at least materially help the human body to assimilate diffusible calcium; with a rich blood calcium there is associated a corresponding relaxation of the smooth muscle fibers of the digestive tract with resultant diminution in frequency of spasm of stomach, pylorus, duodenum or colon.

Our clinical experience would seem to indicate that this condition does exist.

Summary

1. Analysis of 1,000 consecutive cases each in Iowa and southeastern Florida definitely show in addition to a ratio of incidence of diseases similar to that already found by other investigators, a definite increase in calculosis in the urinary tract.

2. A decrease in frequency of colon disorders of 3 to 1 and a probably associated decrease in peptic ulcer of 2.5 to 1.

3. An increase incidence of urinary calculosis 6.5 to 1 and a probably associated increase in ureteral stricture 6 to 1.

Conclusion

The foregoing tables and experiences would seem to indicate definitely that there is not only an apparent but a very real decrease in frequency of certain types of digestive disease in south Florida as compared with Iowa due directly and indirectly to climatic conditions.

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OUR NEXT STATE MEETING

A BIG BOAT *A BIG CROWD* *A BIG TIME*

SEE ADVERTISEMENT ON PAGE 87 OF THIS ISSUE

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WORRY

It was formerly said that "man dug his grave with his teeth." That was probably true fifty or so years ago when the tempo of life was comparatively slow and the average man took life as it came.

Today, with the rush and hurry of the average American professional and business man, there has developed a new disease which can be aptly called Americanitis. There is too much speed in walking, talking, driving, eating, working and in everything we do. Even our sleeping hours are curtailed. Why all this speed which leads but to an early termination? In all our haste, if someone were to stop and ask us the reason, we could not give an intelligent reply.

This tumultuous living has enabled the great decimator of life—worry—to cut down men in their prime. This juggernaut cuts a wide path through masses of extraordinary, able men and leaves their lifeless bodies in its path.

Worry is the order of the day and, since a man's position is gauged mainly by his income and accumulation of worldly goods, the dollar mark is almost worshiped as a Babylonian god.

But after all, money can buy only a few things in this life. Why should anyone envy vast incessant worries from which the average individual, excepting the physician, is happily spared.

What really constitutes a successful physician? Successful is really an ambiguous word and should not mean riches. That is only one part of success. The successful physician is one who can render increased service with increased knowledge; who can deputize and then supervise instead of trying to do everything himself; who rests when rest is necessary; who can be content with what he possesses and not worry until he is miserable. How true it is worry is the evil of life.

FLORIDA EAST COAST MEDICAL ASSOCIATION MEETING

At the Florida Medical Association Meeting in Ocala on May 14-15, 1935, the Association officers, together with the President and Secretary-Treasurer of the Florida East Coast Medical Association, met and outlined some plans for the meeting to be held in St. Augustine, November 1-2, 1935.

The St. Johns County Medical Society, as host, urges as many as possible to attend this meeting. St. Augustine with its historical background and places of interest should attract quite a number of members from this standpoint, to say nothing of the program. Likewise, there will be many attractions for our members' wives.

The Florida Radiological Society has been invited to hold its meeting along with the Florida East Coast Medical Association and it is hoped that this can be arranged.

The Monson Hotel has been chosen for the headquarters and has submitted the following rates:

Double room with double bed, with bath, $4.00 to $5.00.

Double room with twin beds, with bath, $5.00 to $6.00.

Single room with single bed, with bath, $2.50 to $3.50.

Cheaper rooms without bath may be obtained, if desired. In addition, many other hotels in town are open and also have their dining rooms open; some of these are located on the Bay Front. Besides the meals at the hotels, there will be numerous eating places around and near the headquarters. However, you may expect good meals at reasonable rates and courteous service at the hotel.

There will be a Dry Clinic Friday morning, November 1st, regular meeting at 2 p. m., and banquet at 7:30 p. m. at hotel headquarters, the program ending Saturday at noon. Last but not least, for all those interested in outdoor sports, particularly football, you will note that the Georgia-Florida game will be played in Jackson-

ville on Saturday afternoon. This is only a 45 minute drive from the headquarters and will give ample time to attend the game, for those who so desire.

Watch your Journals for the program and further information concerning this meeting. Remember the time, November 1-2; the place, St. Augustine.

If tickets are desired for the football game, they may be obtained through the Secretary-Treasurer of the Florida East Coast Medical Association. Dr. Reddin Britt of St. Augustine.

FINANCIAL STATEMENT OF COMMITTEE ON MEDICAL POST-GRADUATE COURSES

1933

Registration: 102 @ $5.00		$510.00
Bills Paid:		
Dr. C. G. Coakley	$ 92.48	
Dr. W. A. Mulherin	20.50	
Dr. J. T. Witherspoon	70.00	
Hotel Thomas (expense Dr. Mulherin)	9.75	
Dr. J. A. Kolmer	123.70	
Dr. Wayne Babcock	76.89	
Russell Mitchell (machine operator)	5.00	
White House Hotel	7.50	
Pepper Printing Co. (printing)	15.00	420.82
Balance		$ 89.18

(Signed) G. C. TILLMAN,
Committee Chairman.

1934

Balance in Bank at end of 1933	$ 89.18	
Registration: 89 @ $5.00	445.00	$534.18
Bills Paid:		
Dr. J. A. Kolmer	138.65	
White House Hotel	34.01	
Chicago Lying-in Hospital and Dispensary (film)	10.00	
Dr. Horton Casparis	59.04	
Dr. John C. Burch	80.90	
L. C. Smith Press	4.80	
University of Florida—Faculty Lunches	12.80	
Gainesville Furniture Co.—shades	30.00	
Pepper Printing Co.—Printing	16.50	
White House Hotel	7.50	
Dr. E. L. King	31.85	
Dr. Wayne Babcock	72.15	
Bank Tax	.20	498.40
		$ 35.78
Bills unpaid:		
Dr. C. Jackson		$ 90.00

(Signed) G. C. TILLMAN,
Committee Chairman.

CORRESPONDENCE

That members of the Association may be familiar with the attitude of the A. M. A. on Sickness Insurance, this letter from the Committee on Legislative Activities of the American Medical Association is published.

SICKNESS INSURANCE

To the Editor:

Information coming to the Committee indicates that the action of the House of Delegates at the Atlantic City Session, in consideration of Sickness Insurance, has in some instances not been fully understood. The misconception has to a degree been advanced by reports in some journals and headlines in public newspapers to the effect that sickness insurance has been given broad approval by the American Medical Association. Some groups are said to have planned to act on this supposition.

The report of the Reference Committee of the House of Delegates has been published in the Journal and the Special Report of the Bureau of Medical Economics will soon be available to members of the Association. It is urgently recommended that both the Special Report of the Bureau of Medical Economics, containing an analysis of the various plans at present in operation, and the report of the Reference Committee, which were adopted by the House of Delegates, be carefully studied before any plans are considered. No county society should consider the creation of any new social machinery for the extension of medical service or collection of compensation for such service before the existence of a real need for such change has been demonstrated and the requirements and available existing facilities have been carefully appraised. The report of the Committee states that "Analyses show that the class for which special provision is necessary is far smaller than most lay-writers and the results of so-called 'surveys' would indicate." The economic problems of the individual cannot be adequately dealt with on the basis alone of his classification in the group of those who receive low incomes. Social workers have accordingly long recognized the necessity of the investigation of the problem of each individual. Upon this basis is the method of individual study or "case work" of social service founded. The problem of needed medical service to each person

of the group is also an individual one, and one which cannot be met by group classification.

Based upon an investigation of the resources of the individual, an adjustment of fees for needed medical services, according to ability to pay in graduated installments, in most instances meets the problem of the individual patient who is not wholly indigent. It is to this type of organization that the Legislative Committee referred in a previous communication as meeting public and individual requirements. If the individual is indigent, he obviously cannot be expected to pay for medical service on an adjusted fee basis, nor is he provided for in proposed sickness insurance or any plan other than charitable or direct government indigent relief. In that instance medical costs are only one phase of the individual's economic distress, and his problem requires more comprehensive measures than simple provision of medical services.

A group purchasing an undetermined amount of medical service upon a prepaid fixed premium basis offered to all, within broad income limits, who apply, sooner or later will include a large percentage of individuals who can and have previouly supported medical practice upon normal private basis. Experience has shown that prepayment medical service has not been salable on the basis of adequate fees for the physician, as evident in experience here and abroad.

Some of the effects of such plans are as follows: (1) A large amount of medical work will be done on a financial basis which is inadequate to provide for maintenance of proper standards. (2) Those not included in the plan will be educated to demand medical services at correspondingly low fees. (3) The operation of such plans over a period of average conditions will not add to the sum total of fees derived from the income group insured, and aside from possible temporary changes in distribution will simply reduce more professional services to an inadequate financial basis. (4) The establishment of such plans will create a pattern which, although undesirable, it may be impossible to change or discard, and may therefore lead to still broader adoption of objectionable practices. (5) There is reason to believe that some local plans, even though now apparently satisfactory, inherently possess the same weaknesses and destructive tendencies as have been evident in similar patterns of operation in foreign countries. (6) The questions of contract practice, legal responsibilities, and state insurance regulations encountered, as well as the drift to solicitation of patients and violation of medical ethics cannot be presented here. (7) Extensive systems of voluntary sickness insurance invite competitive offerings by irresponsible people, and in Europe have created conditions so chaotic as to advance the establishment of compulsory insurance by legislative act.

Less populous communities in which the medical and financial needs of the individual patients are known to physicians and public relief officers have no need of any cumbersome machinery.

It is to be noted that the action of the American Medical Association did not contemplate the operation of any plans, except by local constituent societies of the American Medical Association, and that in so doing medical societies must be guided by the Ten Fundamental Principles adopted in June, 1934.

All proposed plans of county societies should be submitted to officers and appropriate committees of state medical societies. Before considering any program, it would also seem advisable to confer with the Bureau of Medical Economics of the American Medical Association which has the greatest opportunity to study the needs for and varying successes of the existing experiments.

Great responsibility rests upon state and local medical organizations and upon delegates, who entered into the consideration and adoption of these reports, to see that the action of the House of Delegates be not construed as approving or encouraging the establishment of local sickness insurance units embracing the objectionable features against which the profession, as a national body, is making such a determined and effective fight.

Committee on Legislative Activities of the American Medical Association.

E. H. Cary, M.D., Chairman;

C. D. Wright, M.D.,

F. S. Crockett, M.D.,

R. L. Sensenich, M.D.

STATE NEWS ITEMS

Dr. W. M. Rowlett of Tampa, accompanied by Mrs. Rowlett and daughter, Gregory, sailed on the S.S. Normandie July 31 for Europe where the doctor will spend two months visiting clinics.

* * *

The Committee on Public Relations has just announced that radio broadcasting, under supervision of the Committee, will be resumed during the early part of September.

* * *

Dr. E. Porter Webb of Crestview died May 26, 1935, at the age of 63 years. Dr. Webb graduated from the Georgia College of Eclectic Medicine and Surgery in 1902. He practiced at Crestview for many years and was an active member of the Walton-Okaloosa County Medical Society until in March, 1935, when he retired.

* * *

Dr. John W. Hodges of Miami is spending the summer at Hampton, Virginia, visiting at the home of his daughter. He expects to return to Miami in October.

* * *

Dr. H. A. Day of Orlando, president of the Florida State Board of Medical Examiners, was recently reappointed by Governor Sholtz for a term of four years.

* * *

Dr. Robert B. McIver of Jacksonville was elected president of the Chattahoochee Valley Medical Association at a meeting held in Radium Springs, Georgia, during the month of July. Dr. Edward Jelks of Jacksonville was chosen as director for a five-year term. Dr. Frank K. Boland of Atlanta is secretary-treasurer of the organization.

* * *

The Board of Trustees of Flagler Hospital, St. Augustine, recently elected Dr. Herbert E. White as Chief Surgeon of the Hospital.

* * *

Dr. S. G. Hollingsworth of Bradenton, a member of the State Board of Medical Examiners, was recently reappointed to that position by Governor Sholtz.

* * *

Dr. and Mrs. J. M. McClamrock of Miami announce the birth of twin daughters on July 11.

The Eighth Annual Graduate Fortnight of the New York Academy of Medicine will be held October 21 to November 2 and will be devoted to a consideration of "Diseases of the Respiratory Tract." A complete program and registration blank may be obtained by addressing Dr. Frederick P. Reynolds, 2 East 103rd St., New York, N. Y.

* * *

Dr. William D. Lithgow of Miami spent the month of July attending clinics at the Post-Graduate Hospital of Columbia University, N. Y.

* * *

Dr. A. T. Cobb, formerly Institution Physician of the Florida State Farm, Raiford, announces his removal to Shamrock, Florida, where he has opened offices.

* * *

Dr. Joseph Matthieu has returned from Europe, having spent three years studying cancrology in Paris and Liverpool. He has opened offices in the Huntington Building, Miami.

* * *

Dr. and Mrs. S. W. Fleming of West Palm Beach recently spent several weeks motoring through the West. Dr. Fleming visited clinics and hospitals en route.

* * *

The regular quarterly meeting of the Florida Society of Dermatology and Syphilology met in Jacksonville, June 29.

The following officers were elected: President, J. Lee Kirby-Smith, Jacksonville; Secretary, Wiley M. Sams, Miami.

A clinic was held at the Duval County Hospital by the Jacksonville members and numerous interesting cases presented.

Present by invitation were: Drs. Howard Hailey and Jack Jones of Atlanta; Drs. Andrew Glaze and C. O. King of Birmingham; Dr. T. M. van de Erve of Charleston; Drs. O. E. Harrell, F. A. Copp, and Lauren Sompayrac of Jacksonville; Dr. S. F. Ricker, Orlando; Dr. S. E. Bray, Savannah; Dr. R. P. Lester, Mobile; and Dr. J. A. Elliott, Charlottsville.

Following the clinic, plans were formulated for the organization of a Southeastern Dermatological Association, members to include practicing dermatologists of Georgia, Alabama, North Carolina, South Carolina, and Florida.

Dr. Joe Elliott of Charlottsville was appointed chairman for the coming year and Dr. Andrew Glaze, of Birmingham, secretary.

Dr. W. M. Rowlett, Secretary of the State Board of Medical Examiners, reports that at the Board examination held in Jacksonville, June 17-18, there were one hundred and fourteen applicants. Eleven were denied the privilege of taking the examination, being graduates of low grade medical colleges. Of the one hundred and three who took the examination, eighty-six passed and have been duly issued licenses. First and second honors went to Emory University graduates, Dr. Marion B. O'Kelley, Jacksonville, and Dr. William P. Hixon of Pensacola. Following are the names and addresses of the successful applicants:

Adams, Charles C. ..... Atlanta, Ga.
Baker, Archie J. ..... Jacksonville
Beach, Mahlon L. ..... Orlando
Bedell, Sullivan G. ..... Jacksonville
Black, Irby H. ..... Baltimore, Md.
Brame, Dorothy D. ..... No. Wilkesboro, N. C.
Branch, Charles H. H., Jr. ..... Tampa
Burbacher, Charles R. ..... Miami
Carlson, Earl R ..... New York, N. Y.
Carroll, B. D. ..... Miami
Carson, Russell B. ..... Orlando
Clement, Walter B. ..... Arcadia
Clements, Ralph M. ..... Chattahoochee
Crouch, Everett C. ..... Jasper
Crowell, Edwin A., Jr. ..... Franklin, La.
Cullipher, Edward W. ..... Elwood, Ind.
DeArmas, Charles R. ..... Tampa
Elam, James O. ..... Miami
Ferrara, John D. ..... Jacksonville
Francis, Frank D. ..... Tampa
Frederick, Albert R. ..... St. Petersburg
Futch, Thomas A., Jr. ..... Thomasville, Ga.
Garrard, Hollis P. ..... Birmingham, Ala.
Gary, Robert E. ..... Waycross, Ga.
Gonzalez, Leo C. ..... Tampa
Gwathmey, George T., Jr. ..... Orlando
Hall, Frank M. ..... Birmingham, Ala.
Hanson, Karl B. ..... Emory University, Ga.
Hester, Marion W. ..... Atlanta, Ga.
Hilborn, Robert R. ..... Orlando
Hixon, William P. ..... Pensacola
Johnson, Albert B. ..... Jamestown, N. Y.
Jordan, Otis L. ..... Tuscaloosa, Ala.
Joyner, Rayburn N. ..... Jacksonville
Knowlton, Horace A. ..... Washington, D. C.
Kupper, William ..... Passiac, N. J.
Levin, Alfred G. ..... Miami
Ley, Charles A. ..... Pittsburgh, Pa.
Lilly, George D. ..... New Orleans, La.
Linder, William ..... Brooklyn, N. Y.
Lisenby, Amsie H. ..... Panama City
Logan, Allen M. ..... Miami
Lovejoy, M. Austin ..... Miami
Lusskin, Harold A. ..... New York, N. Y.
Lusskin, Lillian B. ..... New York, N. Y.
Martin, Clarence ..... St. Louis, Mo.
Martin, Stanley T. ..... Shamrock
Mathers, Fred ..... Gainesville
McCall, Eugene F. ..... Jacksonville
McGugan, Arthur ..... Little Compton, R. I.
McMath, William ..... Americus, Ga.
Mellen, Noel C. ..... Pensacola
Mendoza, Carl C. ..... Jacksonville
Meysenbug, Von Ludo ..... New Orleans, La.
Mimms, Carney W. ..... Hot Springs, Va.
Munnell, Daniel M. ..... Titusville
Nuzum, Russell K., Jr. ..... St. Augustine
O'Kelley, Marion B. ..... Jacksonville
Olaechea, Luis Rey ..... Tampa
Paulk, James R. ..... Union Springs, Ala.
Potter, Glenn J. ..... Kansas City, Mo.
Quillman, Frank L. ..... Roseland, La.
Rash, Jack O. W. ..... Henderson, Ky.
Ray, Roy S. ..... Charleston, W. Va.
Sapp, James W. ..... Havana
Schaeffer, Oden A. ..... Coral Gables
Sellers, William T. ..... Mobile, Ala.
Seltzer, Joseph ..... Orlando
Shaw, James G. ..... Columbia, S. C.
Shell, Paul G. ..... Jacksonville
Simmons, Eugene D. ..... Jacksonville
Smith, James G., Jr. ..... Tampa
Smith, James S. ..... Nashville, Tenn.
Sompayrac, Lauren M. ..... Jacksonville
Stewart, Franz H. ..... Coconut Grove
Stipe, Harvie J. ..... Atlanta, Ga.
Stokes, Roy J. ..... St. Petersburg
Tolle, Robert L. ..... Lake Wales
Tugwell, Wilton E. ..... Pensacola
Turk, John F., Jr. ..... Nelson, Ga.
Walters, William H., Jr. ..... Jacksonville
Ward, Henry H. ..... Venice
Watkins, Thomas ..... Farmville, Va.
Williams, Norman E. ..... Seville
Williamson, Carolyn C. ..... Ormond
Welchel, Lynn W. ..... Douglas, Ga.

The following medical colleges were represented: American Medical Missionary College, University of Arkansas, Barnes Medical College, Bellevue Hospital Medical College, Lyola University of Chicago, University of Cincinnati, Eclectic Medical of Cincinnati, Cleveland Homeopathic Medical College, University of Colorado, Columbia College of Physicians and Surgeons, Duke University School of Medicine, Royal College of Physicians and Surgeons of Edinburgh, Emory University School of Medicine, University of Georgia, Harvard Medical School, University of Havana, Johns Hopkins School of Medicine, Howard University, Indiana University of Medicine, Illinois University, Kansas State University Medical School, Louisiana State University Medical Center, University of Louisville, McGill University, Meharry Medical College, Memphis Hospital Medical College, University of Michigan, University of Minnesota, University of Nashville, Northwestern University Medical School, Ohio State University Medical College, University of Pennsylvania, Woman's Medical College of Pennsylvania, Rush Medical College, Medical College of State of South Carolina, St. Louis Medical College, Temple University of Philadelphia, University of Tennessee, Texas University, Tufts Medical School, Tulane University, Toronto University, Vanderbilt Medical School, University of Virginia, Washington University and Yale Medical School.

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COMPONENT COUNTY SOCIETIES

BROWARD COUNTY MEDICAL SOCIETY

THE BROWARD COUNTY MEDICAL SOCIETY STANDS 100% PAID FOR 1935. THIS ACTIVE SOCIETY HAS A MEMBERSHIP OF TWENTY-TWO, HEADED BY O. C. BROWN, FT. LAUDERDALE, PRESIDENT, and R. E. BLOUNT OF FT. LAUDERDALE, SECRETARY-TREASURER.

DADE COUNTY MEDICAL SOCIETY

The regular meeting of the Dade County Medical Society was held in the Huntington Club Rooms, August 2 at 8:30 p. m. The program, which was in charge of Dr. Joseph S. Stewart, Jr., consisted of reports from those who attended the American Medical Association Convention, held in Atlantic City in June.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

The July meeting of the Pasco-Hernando-Citrus County Medical Society was held in Dade City at the Edwinola Hotel on July 11. Dr. John J. Bourke was host.

After dinner, the doctors adjourned to the hotel parlors where a business and scientific meeting was held. Clinical presentations were made of fracture cases by Dr. Bourke. Dr. John R. Boling of Tampa held a symposium on Fractures.

ST. JOHNS COUNTY MEDICAL SOCIETY

Dr. and Mrs. Robert McIver of Jacksonville entertained the St. Johns County Medical Society at their summer home at Ponte Vedra, which is in St. Johns County, during the month of July. After a buffet supper, Dr. McIver gave a talk on "Urological Problems" and Dr. Shaler Richardson presented "Some Ocular Conditions of Interest to the General Practitioner," illustrated with lantern slides. Those present report a most enjoyable evening.

The St. Johns County Medical Society reminds all readers of the Journal of the Florida East Coast Medical Association meeting which is to be held in St. Augustine November 1 and 2. A preliminary announcement of this meeting appears elsewhere in this Journal. Further information regarding plans and program will be published from time to time. Watch your Journal for these announcements.

WOMAN'S AUXILIARY

TO THE
FLORIDA MEDICAL ASSOCIATION, INC.
State Editor
MRS. S. M. COPELAND
1356 Willowbranch Ave.,
Jacksonville, Florida

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RECOMMENDATIONS ADOPTED BY THE AUXILIARY TO THE AMERICAN MEDICAL ASSOCIATION AT THE MEETING IN ATLANTIC CITY JUNE 10-14, 1935.

RECOMMENDATION NO. 1

Be it resolved:

That the name of the Corinne Keen Freeman Revolving Fund be changed to read the Corinne Keen Freeman Fund; and, be it further resolved, that the amount of this fund be one thousand dollars and that interest payable be deposited in the treasurer's account.

RECOMMENDATION NO. 2

Be it resolved:

That one hundred seventy-nine dollars and twelve cents be added to the Corinne Keen Freeman Revolving Fund, making the amount of that fund one thousand dollars.

RECOMMENDATION NO. 3

1. That the States use more discretion in the selection of Organization Chairmen. This is the most important office and necessitates the rendering of complete reports. One who is experienced and has demonstrated her ability should be chosen.
2. That the National Board agree upon a standard report to be used from year to year, as this will give valuable statistical data.
3. That the Organization Chairmen not be

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changed yearly because it takes at least one year to become acquainted with the work.

4. That the budget be increased to $50.00 for Organization Chairmen and $35.00 for each District Chairman. It is impossible for Organization Chairmen and District Chairmen to travel or make contacts on the present budget.

5. In States where counties have less than ten doctors in the county that they organize into districts.

6. That a detailed survey be made of members that have discontinued their membership to ascertain the reason why.

7. That Organization Committee appear on the stationery of the National Auxiliary so that correspondence will be directed to the right source for organization work.

Mrs. R. K. Packard, Chairman,
Organization Committee.

Recommendation No. 4

1. The continuation of the Public Relations Educational Program through Health Programs, Health Institutes and Essay Contests.

2. That Auxiliaries continue co-operation with local Parent-Teacher groups in their Health Program by urging periodic health examinations of school children in the office of the family physician in preference to mass clinics.

3. The promotion of Hygeia Exhibits at County and State Fairs with Auxiliary members serving as hostesses and distributing A. M. A. health literature.

Mrs. David S. Long, Chairman,
Committee on Public Relations.

Recommendation No. 5

We recommend that the budget be based on our income which at the present time is derived from national dues to be expected for the following year. We present the following budget for 1935-1936. Also we recommend that in the president's budget, the discretionary fund, supplies and clerical help not be budgeted separately but be covered by one amount, and that likewise postage, express, telegrams and telephone come under one budget, thus relieving the president of

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some seemingly unimportant bookkeeping and allowing for more discretion on her part as to where the money should be used. Furthermore it is our recommendation that all dues received in excess of the amount budgeted for, be added to the president's account.

Assets available for Budget—Estimated Dues	$3,200.00	
President's Office:		
Discretionary Fund, Supplies and Clerical Help	$1,050.00	
Postage and Express, Telephone and Telegraph	175.00	
President's Pin	40.00	
		$1,265.00
Treasurer		100.00
Recording Secretary		50.00
Standing Committees:		
Organization	$ 155.00	
Program	400.00	
Finance	10.00	
Printing and State Supplies	200.00	
Public Relations	125.00	
Hygeia	200.00	
Revisions	10.00	
Press and Pubilicity	200.00	
Historian	10.00	
Convention	550.00	
Archives	10.00	
Exhibits	25.00	
Miscellaneous and Proceedings of Annual Meeting	75.00	
		$1,970.00
		$3,385.00

Mrs. William O. La Motte,
Chairman, Finance Committee.

Recommendation No. 6

"That the National Auxiliary recommend to the States that each State observe annually a day of appreciation of the struggles and sacrifices that the Medical Profession has made in the defense of human living throughout the ages—such a day to be called 'Doctors Day' and to be selected by each State in commemoration of some member or notable advance in the Medical Arts of that State."

Mrs. E. R. Harris,
Pres. Georgia Auxiliary.

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Underlying the gay, carefree boulevard life which pervades the city is a charming suggestion of subtle antiquity and old world influence ... the famous Prado, the Malecon and then an excursion down one of the narrow side streets afford an intimate glimpse of the new and the old.

The plans for the Sixty-Third Annual Meeting of the Florida Medical Assaciatian, Inc., which will be held on board the luxuriously appainted passenger liner "FLORIDA", include a day ashare in the beautiful city of Havana.

ADVERTISERS' NOTES

Carbarsone, Lilly

Medicinal agents containing arsenic should be of the highest degree of purity and of proved safety. The finished product conforms to these high standards only if the same standards have been applied to the crude materials and intermediates that enter into the manufacture of such an item as Carbarsone, Lilly (p-carbaminophenyl arsenic acid), introduced in 1931 and extensively used with marked success in the oral treatment of amebiasis.

In the production of this arsenical, the arsenic content is quantitatively determined and the amount of arsenic found in the assay must be held within narrow limits of tolerance. Toxicity tests are also applied to each manufactured lot of Carbarsone, Lilly, in order to insure its safety and to provide a record of its physiologic performance. Extremely low limits are maintained on the moisture content of Carbarsone, Lilly, and also upon the amount of ash that remains when a sample is ignited to constant weight. Other tests are applied to check the purity of the product as, for example, the test which proves the absence of chlorides. In prescribing Carbarsone, Lilly, for the treatment of amebiasis, every physician should feel that in the development, the production, and standardization of this delicate product the manufacturer is accepting full responsibility for its potency and uniformity. A booklet on Carbarsone, Lilly, is available for the asking. Address the Lilly Research Laboratories, Box 618, Indianapolis, Indiana.

Exhibit of National Drug Co. at A. M. A. Convention

This scientific exhibit of The National Drug Company consisted largely of Antitoxins, Curative Serums, Specific Vaccines as used for the diagnosis or treatment of Diphtheria, Gas-Gangrene, Scarlet Fever, Pneumonia, Meningitis, Streptococcus and Staphylococcus infections, Erysipelas, Tuberculosis, Rabies, Small Pox, Typhoid Fever, as well as specific Antigens for the desensitization and treatment of Hay Fever, Ivy and Oak poisons and assayed and standardized galenicals. A large oil painting of The Biological Laboratories located at Swiftwater, Pa.,



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to furnish an adequate amount of these vitamin factors in a palatable form, unobjectionable to the most finicky of patients. Years of intensive research on nutritional problems have led to the development of Haliver Oil with Viosterol as an excellent source of Vitamins A and D.



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in the Pocono Mountains served as a background for the exhibit.

The entire time of the five service representatives was given to explaining the various products accepted by The Council on Pharmacy and Chemistry of The American Medical Association. The main trend of advancement in biological science is in the direction of prevention (immunizing) patients against infectious or contagious diseases.

The National Drug Company is particularly interested in the development, and refinement in processes, of the newer biological products. Especially is this fact demonstrated by the high concentration, rigid standardization and refinement of Antitoxins and Serums, as well as Refined Diphtheria and Tetanus Toxoids, which eliminate a very large proportion of the non-essential proteins. These refinements make it possible to give maximum potency or unit value in smaller bulk thus making for quicker absorption and consequently more rapid therapeutic results. The pain of injection is minimized and above all the ratio of protein reactions causing a rash, or serum sickness, is very materially lessened.

The policy of The National Drug Company in confining distribution of their products exclusively to the medical and pharmaceutical professions, to abstain entirely from advertising or sales promotion through lay publications thereby inducing self-medication, is one that merits the full approval of the professions of pharmacy and medicine.

The complete biological catalogue is now off the press and a copy will be mailed to physicians writing The National Drug Company, Stenton and Wyoming Avenues, Philadelphia, and mentioning this Journal.

A complete immunizing treatment of Refined Tetanus Toxoid to prevent Tetanus will also be included with the Biological List.

The Borden Digest

SUMMARY OF JULY ISSUE

Nutrition as the most significant factor in improving the health and longevity of the human race was the cogent topic selected by Dr. J. S. McLester for his presidential address at the recent meeting of the American Medical Asso-

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IN CASES of tonsilitis, pharyngitis, peritonsillar abscess, retro-pharyngeal abscess, cervical adenitis—

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ciation in Atlantic City. This important paper, in which the unique value of milk in human nutrition is emphasized, is reviewed in Abstract No. 73.

Irradiated evaporated milk containing 125 U.S.P. units of vitamin D per 14½ ounce can was shown by the clinical test reported in Abstract No. 74 to be an adequate agent for preventing rickets in Negro infants.

Lactose does not increase blood sugar and does not cause hypoglycemia in normal persons, and only slight changes in the obese, but it causes marked changes in diabetics, according to the study outlined in Abstract No. 75.

An abundance of sugar in the diet does not cause dental decay when the ration contains sufficient vitamins and minerals, as shown by the experiments with laboratory animals which are summarized in Abstract No. 76.

The successful raw apple method for the treatment of infantile diarrhea is described in the interesting paper which is the basis of Abstract No. 77.

All aspects of Brucellosis, or undulant fever, are dealt with in the article mentioned in Abstract No. 78, in which the value of pasteurization of milk in the prevention of disease is stressed. Although the use of sera and vaccines is stated in this paper not to have been found satisfactory, a report of a recently developed antiabortus serum is given in Abstract No. 80. In Abstract No. 79 there is a brief report of a case of undulant fever due to goat's milk.

A new book on infant care for mothers is reviewed in Abstract No. 81, while the last annual report of the International Association of Milk Inspectors is summarized in Abstract No. 82.

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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	Harry M. Merchant, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	92%
Bay	Allen H. Miller, M.D., Millville.					80%
Brevard	Bob Schlernitzauer, M.D., Rockledge.	2nd Tuesday		Varies	Yes.	77%
Broward	Robert E. Blount, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	100%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	98%
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.	2nd Tuesday	8:00 P.M.	Varies	Yes.	100%
Duval	Charles B. Mabry, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	63%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	55%
Hillsboro	John S. Helms, Jr., M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	91%
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	83%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	95%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	8:00 P.M.	Varies	Yes.	82%
Madison	Geo. O. Davis, M.D., Madison.					100%
Manatee	W. D. Sugg, M.D., Bradenton.	3rd Tuesday	7:00 P.M.	Whitfield Country Club Bradenton	Yes.	75%
Marion	Richard C. Cumming, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	100%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	John A. Pines, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	96%
Palm Beach	Lloyd J. Netto, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	100%
Pasco-Hernando-Citrus	John J. Bourke, M.D., Dade City.	2nd Thursday	7:00 P.M.	Varies	Yes.	100%
Pinellas	O. O. Feaster, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg. St. Petersburg	No.	94%
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	100%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	86%
St. Johns	John L. Bennett, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okeechobee-Indian River-Martin	E. B. Hardee, M.D., Vero Beach.	3rd Thursday	8:00 P.M.	Varies	Yes.	71%
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	93%
Seminole	J. T. Denton, M.D., Sanford.	2nd Monday	7:00 P.M.	City Hospital Sanford	Yes.	100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	C. A. O'Quinn, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	100%
Volusia	Hugh West, M. D., DeLand	2nd Tuesday	7:30 P.M.	Varies	Yes.	87%
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



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THE JOURNAL
— OF THE —
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Florida Medical Association, S.S. Florida, May, 1936
American Medical Association, Kansas City, Mo., 1936.
Southern Medical Association, St. Louis, November 19-22, 1935

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FOOD IN THE OPEN CAN

● One question commonly asked concerning canned foods is whether or not the contents of the can should be removed to another container immediately after opening. This question has its origin in the belief that if food is allowed to remain in the can after opening, it will absorb an injurious substance from the can and thus become hazardous to the health of the consumer.

For this belief there is not the slightest foundation of fact. Its origin probably lies in the old "ptomaine" concept of food poisoning. Why it should persist in the light of present day knowledge is a mystery. The belief that food must be emptied immediately from the can has been as thoroughly discredited as the "ptomaine" theory of food poisoning (1).

Food poisoning is usually caused by the ingestion of food containing certain bacteria or their metabolic products. It is, in most instances, the direct result of improper preparation, handling, or storage of food (2) (3).

We have previously described in these pages how all canned foods are subjected to thorough heat treatment which destroys not only pathogenic bacteria and their products, but also the most resistant organisms which may cause spoilage. Consequently, the freshly opened can is the cleanest container in the average kitchen.

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With certain foods, it is desirable from the standpoint of quality to remove the food from the can. Such foods, usually those of an acidic nature, may act slowly on the can after air is admitted and small amounts of tin and iron may be absorbed. The traces of these metals have been shown by a Government laboratory to be entirely innocuous (3), but iron in particular may impart a slight taste to the food.

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230 Park Avenue, New York City

(1) Journal American Medical Association, 90, 459, 1573 (1928)

(2) Preventive Medicine and Hygiene, M. J. Rosenau, Appleton-Century Co., N. Y. 5th Edition

(3) Food-Borne Infections and Intoxications, F. W. Tanner, Twin City Printing Co., Champaign, Illinois

This is the fourth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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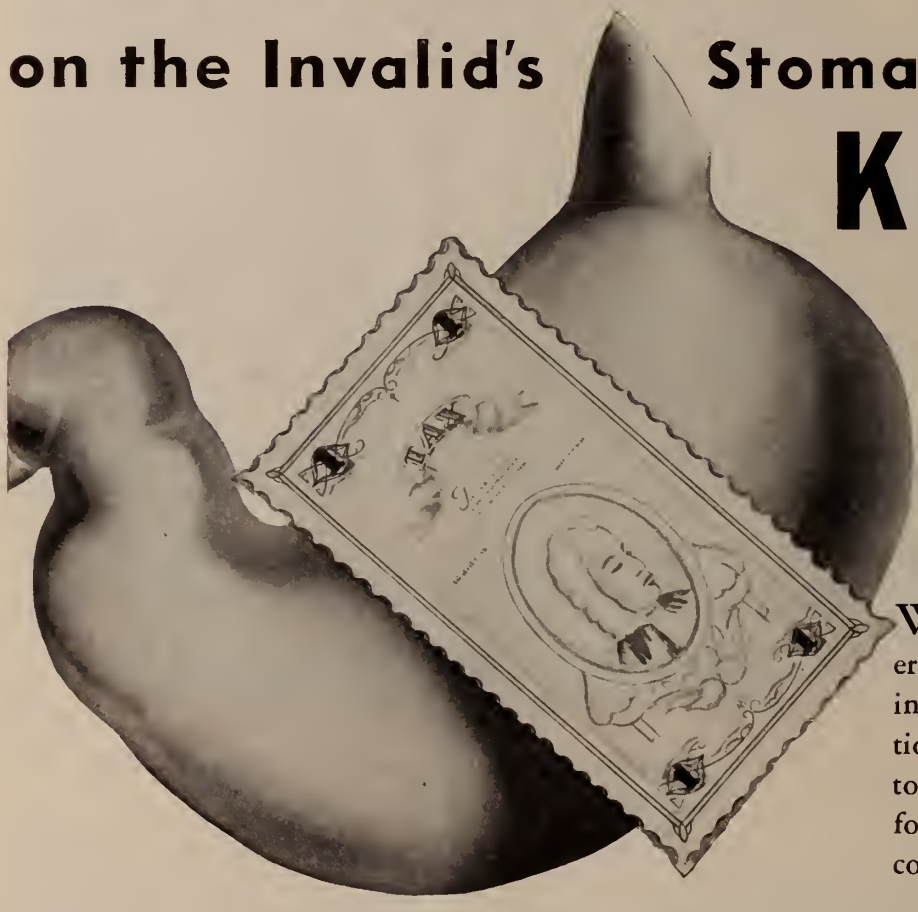
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume XXII | Jacksonville, Florida, September, 1935 | Number 3

MATERNAL MORTALITY IN FLORIDA AND SUGGESTIONS FOR CORRECTION*

HENRY HANSON, M.D.,
State Health Officer,
Jacksonville.

About two years ago I wrote to the County and District Medical Societies of the State asking them to appoint a committee to study the causes of the mortality among mothers at the time of giving birth to babies, or deaths attributable to pregnancy and childbirth. The response was gratifying in some sections; in others there was no reply to the letters sent out.

The members of this Association know that Florida has had an unfavorable position due to prevailing high maternal mortality. The rate per thousand live births has been the highest of any state in the Union. In an article which I read before the Public Health Section of the Southern Medical Association, I included a table showing what the rate has been during the ten-year period 1923 to 1932, inclusive, and the total number of deaths for each race, white and negro, for that period. The totals were given for 1933 for both races but not for each separately. The distressing feature of the statistics for the eleven years mentioned is that the combined rate (both races) for 1933 of 11.1 is the highest since the year 1925, when it was 11.3 per thousand live births. The white rate for 1925 was 9.3 and the negro rate was 15.6 as compared with 8.7 for whites and 16.2 for negroes in 1933. We have striven to do something to improve the standing of the State, but a continued low maternal mortality will not be realized without the full cooperation of the medical profession of the State.

I have felt encouraged by the results of the last year, 1934, when the total deaths were 219 with a rate of 8.2 for both races.

*Read before the Sixty-second Annual Meeting of the Florida Medical Association, Ocala, May 13-15, 1935.

RECORDED DEATHS FROM THE PUERPERAL STATE AND RATES PER 1,000 LIVING BIRTHS REPORTED, BY COLOR, FLORIDA, 1934.

TOTAL			WHITE			COLORED		
Births	Deaths	Rate	Births	Deaths	Rate	Births	Deaths	Rate
26,694	219	8.2	18,589	127	6.8	8,105	92	11.4

On a percentage basis there were 27% fewer deaths.

On the basis of rate per thousand live births the 1934 rate is 2.9 below 1933. The white rate is 1.9 below what it was in 1933, and the negro or colored rate is 4.8 lower than it was in the previous year. For the pronounced lowering of the negro mortality a great deal of credit is due Miss Ely, who has been our supervisor of midwives, and who has conducted the institutes and midwife education work.

Deaths among white women were 127 with a rate of 6.8 and deaths among negro women were 92 with a rate of 11.4. This is only .3 higher than the combined rate for 1933. While this has been encouraging, in pointing to a solution as a result of adequate obstetrical care, it is a fact that the rate is still double what it should be. I believe that some of the reduction achieved is largely due to our increased nursing service as I indicated in the article read in San Antonio, and to the improvement in the preparation and equipment of the midwives, as well as increased medical attention for mothers carried on the relief roles. The enlarged nursing staff has made possible the holding of institutes for midwives in different parts of the State. In these not only the midwives were given instruction but the institute has served as an instructive review for most of the nurses assigned to the public health work.

In an analysis of the ages of those dying we find the following:

Age	Total	White	Colored
10-14	3	0	3
15-19	51	20	31
20-24	61	34	27
25-29	64	34	30
30-34	43	28	15
35-40	51	30	21
40-44	7	6	1
45-49	4	2	2
Unknown	1	0	1
	285	154	131

The causes of deaths as they were reported to the Bureau of Vital Statistics are:

		Total	W	C
(141)	1933—Abortion with septic conditions..	33	24	9
(141)	Abortion without mention of septic conditions	12	5	7
(142)	Ectopic gestation	1	0	1
(143)	Without mention of septic conditions	3	3	0
(144)	Puerperal hemorrhage, placenta prev.	6	5	1
(145)	Other puerperal hemorrhages	14	9	5
(145)	Puerperal septicemia (pyemia, etc.)	76	33	43
(146)	Albuminuria and eclampsia	78	40	38
(147)	Other toxemias of pregnancy	9	3	6
(148)	Puer. phlegmacia Alba dolens embolus	13	7	6
(149)	Cesarian operations	4	4	0
(149)	Other accidents	37	24	13
(150)	Unspecified	1	0	1

Deaths From Diseases of Pregnancy, Childbirth and Puerperal State and Death Rates Per 1,000 Live Births, By Color, Florida, 1924-1933

Years	Total	Rate	White	Rate	Colored	Rate
1933	285	11.1	154	8.7	131	16.2
1932	262	9.6	149	7.9	113	13.2
1931	267	9.9	142	7.6	125	14.9
1930	267	9.9	155	8.3	112	13.3
1929	255	9.5	144	7.9	111	13.0
1928	280	9.4	175	8.5	105	11.5
1927	352	10.3	202	8.5	150	14.7
1926	357	10.3	214	8.6	143	14.5
1925	330	11.3	186	9.3	144	15.6
1924	284	10.6	138	7.6	146	16.9

An analysis of deliveries in the practice of doctors and midwives shows that approximately 66% of the white babies were delivered by doctors, and 32% to 34% by midwives. Among the negroes, 19% to 21% were attended by doctors and 78% to 81% by midwives. The above figures cover the years 1929 to 1932, inclusive. The relative mortality for doctors and midwives has not been worked out.

Previous to the session of the State Legislature in 1931 there was no law governing the practice of midwifery, and all one could do along lines of control was by bluff or persuasion. The midwife control law improved things considerably but was soon found weak in that there was no penalty clause for those who continued to practice midwifery without a license, and the poorest work was among that group.

If one could consider deaths in pregnancy under one general heading it would occupy 11th place among the twenty leading causes of deaths for the year 1933. On the same basis it occupied 9th place in 1924.

Some have questioned the comparability of our statistics and intimated a possibility of difference in classification as compared with other countries, and that our record in actuality is not as bad as I have shown it. Unfortunately, there is no solace to be gained from that quarter. Our statistics have been analyzed and compared with the statistics of other countries as well as with other States and we still maintain our unenviable reputation. I am bringing these data to your attention because I feel that the medical profession can do more than any other organization to bring about a lowering of the maternal mortality.

We have made progress in bettering the midwife situation in the state. The classes and institutes for midwives have improved their services in every respect. We hope to have a new law or an amendment which will stop a group of male midwives as well as white and negro women who are practicing without a license. We have strong circumstantial evidence that there have been cases of tetanus neonatorium as a result of men without medical or obstetrical training attending women in labor. Negro men have attended white women. There are many sections too far away from a physician to obtain other than a midwife's services, and for such we must develop the best possible midwives. With the amended law I am confident that we will soon have the midwives under control and that we can bring about a fairly prompt reduction in the mortality among women attended by them. In this respect our greatest difficulty has been among a class of white midwives with an outlaw spirit, who have defied the public health nurses, knowing that there is no penalty clause in the 1931 law.

We do not at present have full information as to the causes of the Florida mortality. I am asking each County Medical Society to make a careful study of the mortality and determine the cause in the territory covered by the societies. At some time I should like to meet with a representative of each Society for a frank discussion of causes and to offer suggestions for the lowering of the mortality.

I have great respect for the medical talent in Florida and feel that it is an unjust reflection on the profession for Florida to continue showing the highest maternal mortality of any state

Twenty Leading Causes of Death, Florida, 1933.

CAUSES	Deaths
Heart Disease (all forms)	3,053
Nephritis (all forms)	1,824
Cerebral Hemorrhage	1,366
Cancer (all forms)	1,284
Tuberculosis (all forms)	1,039
Pneumonia (all forms)	917
Influenza (all forms)	608
Automobile Accidents	495
Syphilis	450
Malaria	373
Homicide by Firearms	254
Diabetes Mellitus	246
Diarrhea and Enteritis	230
Appendicitis	213
Hemiplegia	213
Pellagra	193
Other Diseases of the Stomach	190
Traumatism by Fall	183
Arteriosclerosis	154
Accidental Drowning	144

in the Union. When you, the medical profession of Florida, make a serious study of this matter we will enjoy a better reputation in this country.

TWENTY LEADING CAUSES OF DEATH, FLORIDA, 1924.

CAUSES	Deaths
Heart Disease (all forms)	2,111
Tuberculosis (all forms)	1,054
Nephritis (all forms)	1,029
Cerebral Hemorrhage	1,024
Pneumonia (all forms)	894
Cancer (all forms)	700
Diarrhea and Enteritis	646
Paralysis without specified cause	356
Homicide by Firearms	268
Other Diseases of the Stomach	265
Malaria	249
Automobile Accidents	243
Measles	214
Syphilis	190
Influenza (all forms)	160
Typhoid	157
Appendicitis	149
Accidental Drowning	141
Arteriosclerosis	139
Intestinal Obstruction	116

DISCUSSION

Dr. N. A. Upchurch, Jacksonville:

When our State Health Officer advised two years ago that we had a high maternity death rate, it was our desire to cooperate and make our State safe for motherhood. We found that Jacksonville had one of the highest maternity death rates of any city in the United States. We secured a midwife law, eliminating those not competent to continue in this service. This was done with the help of the State Board of Health, and today about 85 per cent of our mothers are delivered by physicians. We have instituted a Maternity Hygiene Program for mothers, where they can get examined and prepared for delivery, as we make no deliveries by the department. Since this program was instituted, not a single mother has been lost. It is not our desire to criticise, but to make both the physician and mother conscious that their responsibility is great. The Boards of Health are recognized as your clearing house. There we note all deficiencies. We hope to make Florida safe for motherhood and appreciate every assistance of the physicians to lower the maternity death rate.

Dr. T. M. Rivers, Kissimmee:

I think it is a good idea that we analyze some of the causes for our maternal accidents or losses. It is perfectly natural that we sometimes lose a patient, but let us look into the reason and see that we do not lose the next one from the same cause.

Having worked in rural territory, I come nearer representing the average physician of the State than many of you, and I have made about two thousand deliveries. I recall having been associated either directly or indirectly with the loss of eight mothers. In some of these cases, two or three of them, I was called too late to accomplish much. Two of these deaths were from eclampsia. I think that that is rather a low death rate when we think of the number of cases of eclampsia that we have. Now, we should not lose a patient from eclampsia. The reason that we lose these patients is that we do not see them and give them prenatal care. It is better if we make our clientele understand that we refuse to take over the care of cases which come in incidentally. Make them understand that they should have prenatal care. Of those I mentioned, I think only one had had prenatal care. The other one had no prenatal care whatever. The idea is to teach our clientele that we should know what they are.

The first point then is to know your patient. If you know your patient, and have your patient in hand, understand the pelvic conditions, understand the idiosyncrasy of the patient and understand everything there is about your patient—that is the first step in preventing our losses of mothers.

Another cause is that we get in a hurry. When we have the care of a patient in hand it is necessary that we forget other things. Don't think of the other patient over there with pneumonia, or typhoid fever. Forget them for the time. You can't attend to your obstetric case and these other patients at the same time.

I beg to differ from one discussion on the other paper, that is the giving of anodynes or drugs. Give them early. One of the principal points in saving your patient is conserving your patient's strength. Nature will take care of lots of these cases if you take care of the patient. Conserve your patient's strength by overcoming as much as you reasonably can the amount of suffering in the early stages of labor, in the first stage in the primipara. Conserve the strength of the patient in the first stage and the second stage is more easily handled because she is more able to care for herself.

Dr. Warren Quillian, Coral Gables:

Most statistics are usually based on population. Since the 1930 census figures give Miami a population of 110,637, the percentage of maternal mortality for 1934 is hardly accurate. This

is true because there is an increase of fifty per cent (approximately) each winter in non-resident or tourist population. Recent survey just completed indicates that the population for the Miami area is nearly 200,000. Despite this disparity of figures, and even with this disadvantage, the comparison of maternal mortality and infant mortality rates for Miami with the rest of the country is favorable. Comparison of mortality rates for 1934 with rates for United States Registration Area confirm this observation. This material was taken from the Vital Statistics report for 1934, released by the Department of Health.

Vital Statistics Report, 1934

Comparison of Miami rates for 1934 with rates for United States Registration Area and Florida shows the following for Miami, 1933:

	Registration Area	Florida
Birth rate	0.1 below	0.1 above
Death rate	3.1 above	1.7 above
Infant death rate..... (per 1,000 live births)	2.9 above	3.8 below
Still birth rate..... (per 1,000 live births)	0.4 above	1.7 below

Maternal deaths due to puerperal causes increased from 12 in 1933 to 18 in 1934 for the Miami area. These were divided among white and colored, representing an increase of 5 among colored women, and 1 among white women.

As a corollary of maternal mortality, we should consider infant mortality. An analysis of Vital Statistics indicates that the total infant mortality rate for 1934 in Miami was higher than in 1929-27 or 26. The white infant mortality rate was higher than in any previous year recorded. The colored infant mortality rate was lower than for any year except 1929. The stillbirth rate for 1934 shows a decrease in both white and colored. In spite of an increased population there is a decrease in the number of deaths from communicable diseases. Further interesting information is revealed from a study of charts compiled by the Director of Health in Miami, Doctor George MacDonell, and a compilation of infant mortality rates recently released through the Children's Bureau Department of Labor.

TREATMENT OF INJURIES WITH REFERENCE TO FRACTURES— GENERAL PRINCIPLES*

T. H. Bates, M.D.,
Lake City.

Every fracture presents a problem in emergency surgery. A discussion of the subject of treating fractures necessitates a discussion of the general principles involved. In order to understand the principles which underlie all fracture treatment, it is necessary to consider the subject from a therapeutic standpoint. The definition of a fracture from a therapeutic standpoint would be stated as "An injury to an individual involving a portion of the body in which there exists a solution of continuity in bone."

What does this afford us from the standpoint of our ability to pick out the proper form of treatment for the case in hand? The term "injury" denotes very definite and special pathology. Following fracture there is hemorrhage into tissues surrounding the bone as well as into the bone; there is tearing and destruction of countless number of blood and lymph channels; there is thrombosis of others; there is death of tissue that acts as a local toxic irritant. The net result is an acute inflammatory reaction resulting in marked exudation and cellular infiltration of all these tissues. It results as well in muscle spasm. By the combination of muscle spasm and tension produced by the injury, by reason of this infiltration extensible muscle bellies become inextensible, almost solid bodies which can be torn, but which can not be stretched. At about the same time organization of this extensive process begins. The inflammatory exudate and hemorrhage show beginning of fibroblastic growth which is converted by the process of repair into actual tissue. The process of repair is coincident with inflammation as it is elsewhere in the body, and is not a late sequel to the process of inflammation. In addition to these general changes which are present in all fractures, there is special disturbance of the soft parts in certain fractures. The pathologic lesions of the soft parts include those found in extensive wounds of complicated compound fractures; involvement of nerves and vascular structures which not infrequently occur in certain fractures; in joint involvements, and in muscle tendon injuries, which may result seri-

*Read before the Sixteenth Annual Meeting of the Florida Railway Surgeons' Assn., Ocala, May 13, 1935.

ously by reasons of interposition of tissue necessitating open reduction to avoid non-union.

The second item in our definition is "individual." This factor we must always seriously consider in deciding what form of treatment to use in any given fracture. Fractures occur in Mr. Smith or Mrs. Jones, and not in the text book's "average individual." Because by the use of a certain method, we can secure 75% of good results proved by average statistics is no reason why Bill Smith, who comes to us with a broken forearm, should be treated by that method unless he happens to be one of the 75% who would give good results. Since the individual himself plays so important a part in fracture treatment as opposed to, for example, the surgery of the abdomen, it is only fair that he be taken into consideration. We have to keep in mind that while we may be able to give patients a normal x-ray picture, solid bone union and function which is passively perfect under an anesthetic, the only individual who can use that part as it was used before the accident is the patient himself. In other words, in fracture treatment no matter how perfect mechanically the work may be, unless we secure the active cooperation of the patient to supply the dynamic effort to activate our passive result, all our work has gone for nothing from an economic standpoint.

The individual presents various factors, which may be considered in choosing our treatment. First, his economic status is a matter of some importance. Can he afford to lay up in the hospital in order to undergo a form of treatment which will require a period of weeks in bed and equipment which can be secured only in the hospital? Second, can he afford to be away from work for a given period of time? Third, is he able to stand pain and discomfort with reasonable fortitude? If so, certain forms of treatment may be used, and if not, such forms of treatment may not be used. Fourth, is he intelligent enough to lend his cooperation? If not, can he be jollied into lending his cooperation, or can he be browbeaten into it? If his cooperation can be secured by any of these methods, the form of treatment involved is definitely worth while. If not, the method of treatment becomes perfectly futile. Often in the use of so-called active mobilization in cases where it is obviously impossible to secure the cooperation of the patient, or where the proper method of securing it has not been used, no actual active mobilization occurs, and the method of treatment is branded a failure. This is not so. It is the choice of the method for this particular patient, or the failure to use the proper methods to get the patient's cooperation, which constitutes the defect in the treatment.

Similarly, it may be impossible to carry out various forms of treatment because of physical disabilities existing in the patient; because of general disease; or because of mental or emotional states displayed by the patient. The nature of the occupation, to which the patient must return, also plays an important part in deciding the nature of treatment indicated. This is evidenced in the necessity for the absolute preservation of certain motions, or for great stability in certain regions, or for the preservation of static integrity even at the expense of muscular force and freedom of motion.

Returning again to our definition, we have the term "involving a portion of the body." This again is a matter of considerable importance in deciding upon the method of treatment best adapted to the case. The functions of the upper and of the lower extremities are entirely dissimilar, and call for a different view point in treatment of the two limbs. The first involves flexibility and wide range of motion, while the other involves weight bearing and shifting weight, which we call locomotion. In treating fracture of the upper extremity, we endeavor to secure wide range of motion, and extreme flexibility, with the best anatomic results possible under these circumstances. For instance, an impacted fracture of the neck of the humerus is analogous anatomically to a fracture of the neck of femur with impaction and coxa vera deformity. In the neck of the humerus with impaction, no attempt at reduction is made; the part is started on immediate active motion within pain limits and immediate physiotherapy for the removal of soft part lesions. The anatomical deformity is to all intent and purpose neglected, in order to regain as early as possible, full range and flexibility of motion, and in order to put the soft parts in the best possible condition for regaining that function. In the fractured neck of the femur, meticulous reduction to the anatomical normal is practiced, the part is extensively immobilized for a long period of time, following which a brace support is worn for quite some time. The basis for this vast difference in treatment in analogous

fractures, is nothing but the difference in function in the two extremities.

"The solution of continuity in bone." The final item in our definition begins now for the first time to play its part in deciding which of the methods, not already eliminated by consideration of the previously mentioned factors, we are going to use. The bone lesion exerts its influence through the nature of the line of fracture (whether it be transverse, oblique, spiral or comminuted), through the amount of displacement and distortion which the fracture shows; the existence or non-existence of interposition of soft parts between bone ends, and through the involvement or non-involvement of the joint surfaces.

With this conception of what a fracture is from a therapeutic standpoint, we can consider the aims of fracture treatment which can be briefly stated as the restoration, insofar as possible, of the individual to his former usefulness, in the shortest possible time, with as complete restoration of normal anatomy as can be accomplished under the circumstances. We have already considered most of the factors involved, but there are two others worthy of consideration. The first is the equipment with which we have to work and the second is our familiarity with, and our skill and training in, the method of treatment we are to use. It is a mistake to attempt the carrying out of forms of treatment known to be good, but for which we have neither the proper assistance, nor equipment. It is much better for the patient if we use a theoretically less effective method but for which we are fully equipped. It is again a mistake to employ a method with which we are unfamiliar or about which we are hazy, or to employ a method such as operative treatment which requires specific skill, knowledge, and training if there are other methods with which we are familiar and which we understand. The importance of these two factors cannot be overstated.

"The applied principles of fracture treatment" will consist of, first, a minimal initial examination. If you can determine by simple inspection that a fracture is present, you should not subject the patient to unnecessary handling of further examination. Unnecessary palpation or manipulation is capable of doing much harm, and there is no need to speculate on position of fragments, interposition of soft parts, etc. Second: immediate immobilization, as extensive as possible. This is perhaps the most important first aid procedure with reference to fractures. Its purpose, of course, is to minimize the amount of inflammatory reaction; to prevent further damage to the parts; to spare the patient pain and distress, and to allay the muscle spasm which will interfere with our reduction. Perhaps the best form of emergency treatment in immobilization for either extremity is the Thomas splint with fixed "Spanish windlass" traction. This can be applied rapidly with practically no trauma; maintains constant traction on the extremity; and allows transportation, x-ray examination, and clinical examination with a minimum of damage to the patient. All ambulances should be equipped with arm and leg Thomas splints. Every doctor, who has to take care of injuries, should have as part of his office and automobile equipment, at least one Thomas leg splint, and at least one Thomas arm splint. If every fracture of the extremities were to have a Thomas splint applied to it when it was first seen, and were to be kept under traction until such time as definite treatment could be instituted, the amount of deformity and injury to the soft parts following fracture, would be tremendously diminished. The method of applying Thomas splints is simplicity itself. However, recalling the statement just made that it is better to use the method with which we are thoroughly familiar than one which we are not thoroughly trained in, one may apply any type of splint availiable. The ingenuity of the surgeon should suggest improvision of splints from ordinary boards, rolled newspapers, corrugated cardboard commonly used for packing boxes, a folded pillow or a broken stick, no matter what, just so the part is splinted in some way as soon as diagnosis of fracture or probable fracture is made. X-ray examination, if possible, should be made at this time. The ability to diagnose clinically the deformity and displacement present in fracture is a valuable asset to any doctor. On the other hand, x-ray is extremely useful in revealing the bone changes with little trauma to the patient, and is a valuable preliminary to any attempt at reduction. Third: reduction as soon after injury as possible, and always under an anesthetic if possible. By reducing fractures immediately, before both the muscles and soft parts become densely infiltrated and hardened, we are able to secure accurate apposition of the fragments with least effort and therefore with least damage to the patient. In addition, as the tissues become hard-

ened by the inflammatory process, they tend to hold the fragments in the reduced position, if the reduction has preceded this change. With the reduction accomplished, the amount of pathological change in the soft parts is diminished. By using an anesthetic, we are able to reduce the fracture more easily, more accurately, and with less trauma, and without pain and distress to the patient.

After reduction is accomplished a clinical check of the position obtained should be made. It is important to be able, clinically, to estimate position accurately as further reduction can be accomplished then and there if necessary instead of after twenty-four or forty-eight hours when the x-ray shows reduction incomplete. Delayed, secondary reductions do a great deal of harm; are more difficult to effect; and are more trying on the patient. X-ray check should always be employed for legal protection and for details of injury and position. The present-day use of a fluoroscopic control has much to recommend it but one must remember that exposure under the fluoroscope carries with it potential danger for both the doctor and patient. It does not substitute for clinical examination which gives you information as to the soft part or x-ray films which give detail and permanent record. Fourth: immobilization following reduction as inextensive as possible for as short a time as possible, and in a position based on future functions rather than on the anatomical site of the fracture. The use of as light splints or retention apparatus as will effectively hold the fracture in the correct position, is to be desired. The upper extremity, for instance, should be immobilized in the so-called effort position while the opposite or gravity position is the one best used for lower extremities. The future function of the part will indicate the best position in which to fix the parts. Immobilization under this principle is based on an entirely different idea of the method advised under the second principle. In this instance we interfere with normal physiologic activity as little as possible. Immobilization is always harmful after the first few days. We wish to hold the functions of the part in abeyance as little as possible. We therefore use by preference, methods of treatment which will immobilize as inextensively and for as short a time as possible. Fifth: the starting of functional treatment as soon as possible after injury. This comprises the use of active motion; aided and resisted; physical therapy in all its various forms; occupational therapy; and, best of all, the return of the patient to his normal occupation in a light form, just as soon after the injury as it is possible to manage it. The principle herewith involved is the removal of the lesions from the part, and the resumption of normal activity as early as possible so that when the bone is healed the parts activating it are normal.

These five principles, then, based on physiological grounds cited under each, are to be followed in treating every case of fracture.

The Methods of Fracture Treatment: There are only three general methods of fracture treatment, manual manipulation followed by immobilization; traction-suspension; and operative reduction. These methods may be used alone or in combination one with another. Manipulative reduction is the simplest. It takes up little time; requires no particular apparatus; and does not require the stay of the patient in bed or in the hospital. Its disadvantages are that in securing a reduction by manipulative means, a great deal of violence must frequently be used, and often repeated reductions become necessary where good anatomical restoration is essential to the end result. The natural outcome is that in securing anatomical reduction of the fragments, we inflict much more trauma on the patient than did his original injury.

Traction suspension is not an easy method of treatment. It requires understanding of the mechanical principles involved; it requires constant care and supervision to see that these principles are constantly acting; it requires coincident attention to the soft part lesions. The mechanical problem is quite simple. Traction accomplishes the return to length of the bony parts, while suspension accomplishes alignment of the fragments in the proper axis. In this, as in all other reduction methods, rapid reduction should be secured. Apply enough weight to your traction apparatus to effect reduction within a few hours. As soon as reduction has been effected and normal length restored, accurate adjustment of suspension will give normal alignment of the fragments and by lateral pressure displacement to one or the other side may be corrected. When this is accomplished, traction weights may be reduced sufficiently to just maintain normal length.

Operative reduction can be divided into two groups. The first comprises those in which operation is indicated as a primary form of treat-

ment. The second group comprises those in which the operation is a matter of choice. The primary operative group needs operative treatment from the standpoint of the eventual degree of recovery and from the standpoint of the time it takes to secure recovery.

Representative of the group are: (1) fractures of the head of the radius with separation of the fragments; (2) fractures of the carpal scaphoid with separation of the fragments; (3) fractures of the olecranon process with separation of the fragments; (4) fractures of the patella with separation of the fragments; (5) fractures of the anatomical neck of the humerus with complete displacement, whether accompanied by dislocation or not; (6) all fractures in which the interposition of soft parts can be demonstrated at the initial examination or at the primary attempt at closed reduction. This means that if you are unable to pursue the operative treatment of this group of fractures yourself, the best thing for the patient is to get him promptly into the hands of some one qualified by reason of special training, better equipment, or better facilities, to give the proper operative treatment without undue delay. Operative treatment when advised should not be followed unless the following factors are up to the best standards: (1) The familiarity of the surgeon with the pathology, and altered physiology in repair following injury. (2) Proper training in operating on bone. Training in abdominal surgery is not adequate training for operating on bone following trauma. (3) Proper equipment in the way of instruments and apparatus, so that operative procedures can be carried out with minimum of trauma and maximum of effectiveness. (4) Adequate trained personnel and assistants. (5) Surgical technique in both staff and operating rooms which meets the highest modern requirements for bone work.

Lack of adherence to these specifications has been responsible for much of the criticism of operative treatment of fracture. The guiding principles in operation on bones following trauma are: (1) Wide exposure with a minimum of trauma. (2) A minimum of heavy retraction and heavy handling of the soft parts. (3) An anatomical reduction with a minimum of trauma to bone tissue. (4) A minimum of stripping of periosteum. (5) A maximum of asepsis. (6) The fixation of the fragments at operation, wherever possible, so firmly that active use of the part within pain limits can be started very shortly after operation. (7) Utilization of physiotherapy for the whole extremity, except the immediate region of the incision, from the day of operation on.

Compound Fractures: The existence of compounding in a fracture complicates the treatment of the bone lesion, and influences our choice of treatment method. Those compounded from within can be treated from the standpoint of a clean wound except that tight suture should never be practiced. Those compounded from without are best treated, in general, in accordance with the rules laid down for wounds about which we are somewhat doubtful, or in which we are sure of infection. There should be constant watchfulness for concealed hemorrhage, particularly in thigh and humerus fractures. The method of choice in caring for a compound fracture is that method which allows the greatest care of the soft parts. For that reason traction suspension presents a great many advantages, particularly if used in the form of skeletal traction, since it affords constant exposure of the soft parts for inspection, dressings, and wound treatment, and provides accessibility for physiotherapy. Adequate debridement and sterilization must be had in all compound fractures. Bone fragments should not be removed unless grossly contaminated or lying loose in the soft parts without tissue attachment. I should like to add a plea for the continued use of suitable chemical antiseptics, and while many newer forms of chemical compounds have been urged in recent years, one cannot overlook the highly satisfactory results from the use of tincture of iodine or suitable solutions of bichloride of mercury. Compound dislocations are very apt to show late and vicious infection coming on from four to six days after injury, probably due to the tearing of tissues, which results in devitalization and diminished resistance. These should always be treated as infected wounds from the beginning.

Summarizing: The emergency treatment of acute injuries from the standpoint of fractures consists in the constant understanding and application of those general principles which underlie the treatments of all injuries; *i.e.*, the histology and pathology involved; the function of the parts; the economic status of the patient; the personal equation of patient and surgeon; and the sensible and adequate application of the best methods available.

SIMPLE METHOD OF CONTROL OF DIABETICS

T. F. Hahn, M.D.,
DeLand.

The procedure to be outlined as a practical method for the control of diabetics by means of urine studies is offered because of its simplicity, inexpensiveness (an important factor in these days of complaints against the high cost of medical care), and because of its superiority to the usual routine and minimal blood studies in evaluating the diurnal variations of the glycemia and glycosuria. It is self-evident that one daily estimation of the blood sugar (and many have them far less frequently than that) is of no significance as a measure of the pre-absorptive and post-absorptive blood sugar levels. One must have cognizance of the levels before and after each meal, relate these to complications present, and relate both to the amount of carbohydrate and fat ingested in order to know with what type of diabetes one is dealing and what dosage of insulin to give before each meal. This has been emphasized by Peters[1] who states, "The determination of the blood sugar in the post-absorptive period has frequently been recommended as a criterion of the severity of the disease and the efficacy of the treatment. Its value for such purposes is strictly limited. Single determinations mean little. The trend of a series of determinations is more significant, but can be interpreted only after due consideration of all changes in therapy that have intervened." A series of determinations, however, is rather expensive, time-consuming, and annoying to the patient if it involves repeated venipuncture.

This method is not original with the writer. It is in daily use on all patients in Peters' clinic, and is taught to the outpatients so as to enable them to check their diabetes at home. Its chief drawback is that it depends on the active and accurate cooperation of the patient in attending to details concerning his every urination; but it is neither impossible, time-consuming, nor difficult if the patient's interest has been properly aroused and his education in the details complete. Moreover, if the expense, annoyance and time taken in the procuring of blood sugars is done away with, the patient is often more ready to do something for himself.

Peters has stated, "If the maintenance of complete aglycosuria is the primary aim of diabetic treatment, the quantitative measurements of urinary sugar as a clinical procedure assumes a position of minor importance, although it is still necessary for studies of metabolism." If one admits then that the aglycosuria is the aim of treatment in diabetes, and that single determinations of the blood sugar level are valueless because they tell us nothing of the diurnal variations, it is obvious that if a patient, at any time of the day and throughout the day, passes a urine which is sugar free we can feel assured that he has not exceeded his blood-sugar level, and that his carbohydrate metabolism is being adequately controlled. With this in mind the diabetic's urine is studied throughout the day according to the following procedure.

The patient is instructed to procure four quart jars and to label them 1, 2, 3, and 4. All of the urine passed in twenty-four hours is to be passed into various of these jars. We will suppose for illustrative purposes that the patient habitually rises at 6:45.

Into jar 1 is voided all the urine passed between the hours 7 a. m. and 11 a. m. (not including the first specimen passed on arising). Such a specimen will contain sugar spilled over because of too much carbohydrate or insufficient insulin at breakfast. Into jar 2 is passed all urine between the hours 11 a. m. and 4 p. m. Such a specimen will contain sugar because of excessive carbohydrate or insufficient insulin at the noon meal. Into jar 3 is passed all urine between the hours 4 p. m. and 9 p. m. and if sugar is present in it, it will be due to insufficient insulin or too much carbohydrate at the evening meal. Into jar 4 is passed all urine in the evening after 9 p. m., that passed on retiring, any passed during the night and all passed on arising in the morning. Any sugar present in such a specimen will be due to sugar spilled over from the nocturnal metabolism (which in severe diabetics may be considerable).

These specimens are then brought to the physician who assures himself that each one is well mixed. From each specimen are taken eight drops of urine which are separately added to tubes 1, 2, 3, and 4 containing 5 cc. of Benedict's or Fehling's solution, and the mixture of each is boiled one minute (five minutes in a water bath). If a mixture turns green we label it X, if it turns brown or yellow brown we label it XX, and if it turns brick red, it is labelled XXX. The first represents about one-half of one per cent of sugar or less, the second about one per cent and the

third two per cent or over. By charting these results along with the dosage of insulin given at each meal and the amounts of protein, fat and carbohydrate at each meal we can measure the efficacy of the insulin therapy and the amounts of carbohydrate to use at each meal. An illustrative case, one of simple, uncomplicated diabetes is outlined by means of such a chart.

Case: S. M. Age: 54. Sex: male.

Date	Diet			Urinary Sugar Output				Insulin Dosage		
	P	F	C	7-11	11-4	4-9	9-7	B	L	S
1-20	70	90	120	xx	xxx	xx	xx	0	0	0
1-21	70	90	100	xx	xx	xx	x	0	0	0

On January 21 carbohydrate was reduced, chiefly at the noon meal, but sugar spilled over constantly during the day, so insulin was necessary as the diet was almost minimal.

1-22	70	90	100	x	xx	x	x	10	0	5
1-23	70	90	100	x	xx	0	x	10	0	5
1-24	70	90	100	x	xx	x	x	10	0	5

Increase of insulin dosage seemed necessary as the patient still had moderate glycosuria throughout the day.

1-25	70	90	100	0	x	0	0	15	0	10
1-26	70	90	100	0	x	0	0	15	0	10
1-27	70	90	100	0	x	0	0	15	0	10

The urine had now been rendered sugar free as far as the metabolism following the morning and evening meals was concerned, but sugar still spilled over after the noon meal, so a dose of insulin before the noon meal seemed indicated.

1-28	70	90	100	0	0	0	0	15	5	10
1-30	70	90	100	0	0	0	0	15	5	10
2-5	70	90	100	0	0	0	0	15	5	10

For one week the patient had been sugar free on the scheme as given immediately above, but he complained bitterly of the necessity of three injections each day, and an attempt was made to cut out the noon dose by varying the amount of carbohydrate at the various meals. So more was given at supper and less at lunch and more insulin was added to the evening dose to compensate for the increased carbohydrate at that meal.

2-7	70	90	100	0	0	0	0	15	0	12
2-10	70	90	100	0	±	0	0	15	0	12
2-15	70	90	100	0	0	0	0	15	0	12
2-18	70	90	100	0	0	±	0	15	0	12
2-22	70	90	100	0	0	0	0	15	0	12

On this diet, with most of the carbohydrate at breakfast and supper, and the above insulin dosage, the patient has been kept fairly sugar free and on the two daily injections he desires. This method, of course, depends to a great degree on the control of the diet, for if the patient is going to vary his radio daily and do as he pleases as to the amount of carbohydrate used, we can never be sure as to the insulin dosage and its effect, but no control of diabetes is going to be of much avail and value unless the patient is willing to carefully follow his diet.

The time of the collection of the various specimens may be varied in different cases to suit their habits, and each individual must be gradually studied to achieve a balance, but when accomplished one can feel assured of the thoroughness of the control and then teach the patient to continue it for himself. Patients can be taught to do the qualitative urine tests for themselves and keep these simple charts, reporting to the physician if any sugar appears in any of the specimens.

The method is simple, accurate if the details are closely attended to, and can sooner or later be left in the patient's hands. In cases of coma or where any of the specimens show complete reduction, that is over two per cent of sugar, we must, of course, resort to quantitative analyses, such as blood sugars, carbon dioxide combining power determinations and quantitative urinalyses.

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CASE REPORT: FOREIGN BODY (SAFETY PIN) IN ESOPHAGUS

L. B. Nicholson, M.D.,
Lakeland.

Patient E. R., age fourteen months, was sent to the Morrell Memorial Hospital, Lakeland, with a history of having swallowed an open safety pin three months previously. The child was very badly undernourished weighing less than at nine months or two months before swallowing the pin. There was a tracheitis present with a great deal of secretion.

X-ray examination showed foreign body in the cervical esophagus at the cricopharyngeal constriction. It was seen to be a medium-sized safety pin, opened widely.

Exposure was effected at operation with an anterior commissure laryngoscope with point of pin embedded in the lateral wall of the esophagus and surrounded by considerable vascular granulation tissue. Removal was accomplished with considerable difficulty.

An interesting feature about this case is the length of sojourn, three months, of this foreign

body, this being an unusually long time for a pointed foreign body to remain in this location without disastrous results.

This case is reported primarily to stress the importance of a thorough examination in all suspected foreign body cases. Careful and complete x-ray examination will reveal the opaque objects and if non opaque foreign bodies are suspected an endoscopic examination should be made. One should be prepared to deal with any foreign body found at the time of this examination thereby making a second procedure less likely to be needed.

This patient, seen two weeks after the removal of the safety pin, was making satisfactory progress and was rapidly gaining in weight.

The tracheitis which was very pronounced at the time of operation cleared after the removal of the safety pin, and was probably due indirectly to the esophageal foreign body. Likely this was caused by an overflow of secretion into the trachea due to a disinclination to swallow.

BACKACHE—THE GYNECOLOGIC VIEWPOINT*

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Orlando.

Backache is probably the most common complaint that sends women to the physician for a pelvic examination. Most women associate backache with some pelvic pathology, and since examination, particularly of women who have borne children, so often reveals some abnormality, it behooves the doctor to remember that only in about one-third of all cases is backache caused by pelvic disease. In a large series of gynecological cases in which operations were done by Lynch and Ward, backache was present in approximately 50% of all cases.

Backache caused by pelvic disease is always present in the sacral or low lumbar region and usually in the midline. When it is above the lumbar region it is almost invariably produced by some other condition. The distress is usually aggravated before or during the menstrual period, is usually more pronounced after a day's work, and is often relieved by the recumbent position. The pain is hardly ever severe and is usually described as dull, nagging, and constant. The degree of pain depends upon the sensibility of the patient's nervous system to painful stimuli. In some women, particularly the working class, backache is accepted more or less as a natural condition after child-birth, and they will make no complaint unless their attention is directed toward it. In other women with a more highly developed nervous system, the pain will be sufficient to break down their psychic morale with the development of various other subjective symptoms.

In order to appreciate the part that gynecological disease plays in the production of backache, it is necessary to have an anatomical knowledge of the normal position and inclination of the uterus, with its ligamentous, muscular and fascial support, the nerve supply of the pelvis, the parametrium or loose connective tissue surrounding the uterus and enveloped by the two leaves of the broad ligaments, which is so often involved in pelvic infection, and the lymphatic drainage of the pelvic organs. Time will not permit a review of the anatomy of the pelvis, except to mention that the pelvis is supplied by the second to the fourth sacral nerves and the hypogastric plexus of the sympathetic nervous system. Backache is produced by direct pressure on the sacral nerves or by painful impressions that originate within the organs and are conducted by the sensory fibers of the sympathetic to the central nervous system, and are then referred back to the peripheral distribution of the sensory nerves that enter the same segment.

Causes of Backache From Pelvic Disease

(A) Congestion and inflammation—Congestion may be physiological or pathological. Women who have no demonstrable pelvic pathology may have backache at the time of the menstrual period. Cervical lacerations and infections are one of the most common causes of backache in this group. Infection in the cervical glands produce a chronic irritation and cause connective tissue proliferation and inflammatory changes in the deeper structures of the cervix and the infection extends upward through the lymphatics into the broad ligaments producing a parametritis. A posterior parametritis with an involvement of the sacrouterine ligaments causes a very persistent type of backache. When these patients are examined and pressure through the posterior vaginal wall is applied against the sacrouterine ligaments, the backache will be produced or intensified. The sacrouterine ligaments play a very important part in the production of back-

*Read in "Symposium on Backache" before the Florida East Coast Medical Association, October 19, 1934.

ache. They are found short, thick and tender in some women without evidence of pelvic inflammation. A careful history will often show that the cause of this is some unphysiological sexual practice. Tubo-ovarian inflammation will produce backache by painful impressions conducted by the sensory fibers of the sympathetic and may be the direct cause in retrodisplacements or uterine prolapse. Backache from this cause is nearly always aggravated at the time of the menstrual period.

The backache from pelvic inflammatory disease may persist for some months after a well performed operation where the infection has penetrated through the pelvic fascia to involve the nerves of the pelvis. In carcinoma of the cervix, backache is always a late symptom and denotes an incurable condition. It is due to direct invasion and penetration of cancer cells beneath the sheath of the nerves. If this type of pain in the back, hips, or thighs occurs after an operation for cancer, it spells a recurrence.

(B) Pressure—There is a wide divergence of opinion as to the symptoms produced by an uncomplicated retrodisplacement of the uterus. On one side is the opinion that an uncomplicated retrodisplacement produces no symptoms, and that these are always caused by associated pathology. On the other side is the belief that a retrodisplaced uterus, if long continued, always produces a characteristic pathology within itself with the development of symptoms. In order to properly evaluate the significance of a retrodisplacement it is necessary to differentiate between the one due to congenital deficiencies or faulty skeletal development, and the other due to inflammatory diseases or the trauma of labor. Women who have never borne children or who have no history of pelvic infection will be found to have retrodisplacements in about 20% of cases, and in these backache is rarely, if ever, produced by the displacement. About 30% of all women who have had children will be found to have a retrodisplacement and in these backache is common.

Lynch found backache present in 50% of all women with retrodisplacement of the uterus, and was able to relieve it in 81% by a suspension operation. In cases associated with inflammatory or neoplastic pathology the backache is often chiefly caused by the pathology and only partly by the displacement. When the uterus is found enlarged, tender and adherent, due to chronic passive congestion from a long continued retrodisplacement, with painful cystic ovaries prolapsed in the culdesac, no doubt may be felt that a suspension will relieve the backache in that particular case.

All uncomplicated movable retrodisplacements should first be treated with a pessary before the patient is promised that a suspension will cure her backache. The fact that a proper fitting pessary inserted after the uterus is replaced to normal position will relieve backache is proof that an uncomplicated retrodisplacement can and does produce this symptom. Some women can tell the position of the uterus by the presence or absence of backache.

Ovarian tumors hardly ever produce backache, unless they are incarcerated in the pelvis or so large that they distend the abdomen. Backache is more common in fibroids, and if the fibroid is caught beneath the promontory of the sacrum may be so severe as to incapacitate the patient. The pregnant uterus incarcerated in the hollow of the sacrum will produce backache in a like manner.

(C) Pulling—Undue tension on the ligaments and supports of the uterus will produce backache in women who are still in the menstrual age. The symptom is common in young women who have uterine prolapse with cystocele and laceration and relaxation of the pelvic floor. It was present in 71% of Lynch's series who had marked vaginal relaxation, and was cured in 79% by operation. In women who have passed the menopause, backache is usually not produced by uterine prolapse. It is remarkable to see complete procidentia in these cases with entire absence of this symptom. Backache in these cases is usually relieved by recumbent position and returns when the patient is on her feet.

Treatment—The treatment must necessarily be directed toward the cause of the backache. In the congestive or inflammatory group conservative methods of treatment will often suffice. Eradication of an old cervical infection by cauterization or conization of the cervix, followed by measures to produce arterial hyperemia as prolonged hot douches, the Elliott bag treatment or diathermy, are most important. In my experience, the use of foreign protein therapy has been helpful in causing the absorption of the pelvic inflammatory exudate. These patients must also be advised to abstain from sexual indulgence.

The presence of other symptoms may neces-

sitate more radical surgical measures, but it is our belief that with the eradication of the cervical focus the resulting pelvic pathology will take care of itself in a large measure, provided the inflammatory process has not progressed too far.

In the second and third groups due to pressure or pulling, operation becomes usually the procedure of choice. Operation may be deferred and backache relieved in young women with a retrodisplacement, because of plans for other children, by the replacement of the uterus and insertion of an Albert Smith pessary, but most women tire sooner or later of wearing a pessary. A considerable number of acquired retrodisplacements may be cured by this method if done at the six weeks postpartum examination, but if the displacement is of long duration the relief is obtained usually only when the pessary is worn. It is a great mistake to dismiss the patient who has tender retroverted uterus causing backache, after her postpartum examination, by telling her that her uterus will regain its normal position by continuing the knee chest position for a few more weeks. The chances are that it will continue to be retroverted and the opportunity to cure her with a pessary has been lost.

Our preference is for the Baldy-Webster type of suspension with shortening of the sacrouterine ligaments. A perineorrhaphy and colporrhaphy are done if there is relaxation of the perineum with rectocele or cystocele. In uterine prolapse in women past the child-bearing period a Watkins transposition operation may be the one of choice.

In conclusion I wish to stress the importance of a careful history and physical examination in every case of backache. The causes are many, and time, patience, and consultation are often necessary to arrive at a correct diagnosis as to the cause. Because the patient happens to be a woman, do not jump at the conclusion that it is due to a gynecological cause unless there is sufficient evidence to support it. Beware particularly of the congenital type of retroversion, and do not promise that woman that a suspension will cure her backache, because the cause is probably not in her pelvis. Always support the uncomplicated movable type of retrodisplaced uterus with a pessary before advising an operation. If the pessary relieves the backache a suspension will cure it and a grateful patient will be the result instead of a dissatisfied one. Nothing is more embarrassing than to perform a beautiful suspension and have a backache persist. It must also be remembered that a patient may have a backache from several distinct and separate causes and even though some pelvic pathology may be found, which in itself may be thought sufficient to produce the trouble, a search for other causes should not be neglected. The viewpoint of backache must be broad and cover the entire body, and not be restricted too closely to the pelvis.

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THE MAN WHO "FLOCKS BY HIMSELF"

"The physician who does not associate with his fellows runs great risk of falling into one of two errors. Either he becomes an egotist because he fails to see the good work that others are doing, or, if of a timid nature, and faithful in his work, from knowing his own weaknesses so well, he feels that he is immeasurably behind his brothers in the profession. One cannot see where he stands in the race unless he sees both those in front of him and those in the rear."

The above paragraph was published in the bulletin of the A. M. A. and so impressed the writer that he felt that every physician in Florida should read and remember it. How true and human every word of it is!

Many a man who is unusually capable is naturally modest, reticent and retiring. These are good qualities but often are a detriment to the one who possesses them because he fails to impart knowledge which would be most welcomed by his fellows. This hoarding of knowledge does not tend to make for progress of the profession in the community or the nation.

Again, many men do not feel that their fellows can impart any knowledge to them. Therefore, they isolate themselves and go their ways, supreme in the thought that they do not need any assistance from any one.

These two classes of men do not help themselves or others. One is a regular attendant at meetings but is just a good listener. The other will not even attend meetings.

Even though one is a good student and reads assiduously he needs the necessary contact to impress the reading in his memory.

With this knowledge he should take an active part in the discussions of a meeting. The other will find too late that he does not know it all and never will. Attendance at medical meetings is imperative for one of this type as it serves to show him how little one individual knows after all.

Good attendance at medical meetings and active participation in all discussions is necessary for all types of physicians who wish to go forward. We must remember that we either go forward or backward. There is no such a thing as remaining stationary.

FLORIDA EAST COAST MEDICAL ASSOCIATION MEETING

Again the St. Johns County Medical Society, as host, wishes to urge attendance of as many members as possible, together with their wives at the next meeting of the Florida East Coast Medical Association. Remember, if you have not attended a Florida East Coast Medical Meeting you have missed a great deal. The Association, the St. Johns County Medical Society, and St. Augustine, the Oldest City, invite you to attend. This applies to all members of each Society included in this organization, which extends from Duval County through Dade County and includes Orange County. All that is necessary to become a member is to attend the meeting and pay your registration fee.

The program will begin with a Dry Clinic, Friday, November 1st, from 10:00 till 12:00. The scientific program opens at 2:00 P. M., at the Civic Center; banquet and entertainment at 7:30 P. M., at the Monson Hotel, headquarters. The scientific session reconvenes at 9:00 A. M., Saturday, November 2nd; business meeting at 12:00, including election of officers, selection of meeting place for 1936, and drawing of attendance prize. Registration fee for all members is $2.50, which includes banquet and entertainment; visitors and guests $1.50 for banquet and entertainment.

Besides the program, remember the time, November 1-2; the place St. Augustine, the Oldest City in the U. S. A., with its quaint old

places, historical points of interest, namely; the Oldest House, Oldest School, Fountain of Youth, Old Fort Marion, Old City Gates, and in many ways its European atmosphere.

One of the best football games of the season, Georgia vs. Florida, will be played Saturday afternoon, November 2, at Jacksonville. This is but a 45-minute drive from headquarters hotel.

These things should make every one strive to attend the meeting.

See the August Florida Medical Journal for Hotel Headquarters, rates, etc.; also, the October Journal and mails for further information and details of meeting.

PROGRAM
FLORIDA EAST COAST MEDICAL ASSOCIATION

Friday and Saturday, November 1 and 2, 1935.
Monson Hotel, St. Augustine.

Friday, November 1, 1935
10:00 a.m. to 12:00 noon.

Dry Clinic at Flagler Hospital, sponsored by the St. Johns County Medical Society.

SCIENTIFIC SESSION
Civic Center,
2:00 P. M.

1. (Surgery) "Repair of Lacerations"—George M. Green, Daytona Beach.
   Discussion: J. Ralston Wells, Daytona Beach.
2. (Gynecology) "Endometritis"—I. M. Hay, Melbourne.
   Discussion: Walter C. Jones, Miami.
3. (Radiology) "Recent Advances in Radiation Therapy"—Gerard Raap, Miami.
   Discussion: O. O. Feaster, St. Petersburg; Frazier J. Peyton, Miami Beach.
4. (Medicine) "Important Consideration in Handling Diabetic Patients"—T. Z. Cason, Jacksonville.
   Discussion: Louie Limbaugh, Jacksonville; Meredith Mallory, Orlando.
5. (Urology) "Personal Impressions Gained from Fifteen Years' Experience in Treating Gonorrheal Infections"—Roy J. Holmes and Milton M. Coplan, Miami.
   Discussion: E. T. Sellers, Jacksonville.
6. (Urology) "Prostatic Resorption"—Maximilian Stern, Daytona Beach.
   Discussion: Robert B. McIver, Jacksonville; Roy J. Holmes, Miami.

7:30 P. M.
Banquet and Entertainment at Monson Hotel.

Saturday, November 2

SCIENTIFIC SESSION
Civic Center,
9:00 A. M.

7. (Gynecology) "Sterility—Diagnosis and Treatment", (X-ray film demonstration)—Ferdinand Richards, Jacksonville.
   Discussion: Charles J. Collins, Orlando; Homer L. Pearson, Miami.
8. (Dermatology) "Fungus Infections of Hands and Feet"—Wiley Sams, Miami.
   Discussion: J. L. Kirby-Smith, Jacksonville; Alan Brown, Jacksonville.
9. (Public Health) "Communicable Disease Control with Especial Reference to Poliomyelitis"—Henry Hanson, Jacksonville.
   Discussion: N. A. Upchurch, Jacksonville.
10. (Pediatrics) "Problems of the Newborn—A Clinical Viewpoint"—Warren Quillian, Coral Gables.
    Discussion: Chas. Kennon, Miami; John W. Hayes, Jacksonville.
11. (Neurology) "Diagnosis of Brain Tumors"—J. G. Lyerly, Jacksonville.
    Discussion: Percy L. Dodge, Miami; W. H. Spiers, Orlando.
12. Guest Speaker (to be announced).

All papers limited to 15 minutes maximum. Discussions limited to 3 minutes individual maximum.

BUSINESS MEETING
12:00 noon.

Reports of Secretary and Committees.

Election of Officers.

Selection of Meeting Place for 1936.

Drawing of Attendance Prize. (There will be an extra charge of 50c for all those who desire to participate in the usual drawing for the attendance prize).

3:00 P. M.

Football game in Jacksonville. Georgia vs. Florida.

* * *

The registration fee of $2.50 will include banquet and entertainment. For guests and visitors, there will be a charge of $1.50 for the banquet and entertainment.

CORRESPONDENCE

August 20, 1935.

To the Editor:

DEBATE: "MEDICAL SERVICE AT PUBLIC EXPENSE."

The National University Extension Association Debate Committee has announced the subject for debate for 1935-36. The proposition is: *"Resolved:* That the several states should enact legislation providing for a system of complete medical service available to all citizens at public expense."

The choosing of this proposition by the National Committee means that it will be debated by more than 100,000 students in high schools, colleges and universities throughout the United States. The debates will be heard by large and small audiences, in auditoriums and over the radio. It is anticipated that a considerable amount of public interest will be stimulated.

In order to provide students with adequate materials for study of the proposition, the Committee is devoting the eighth annual Debate Handbook to the field of Medical Economics. The editor of the volume is Mr. Bower Aly, Depart-

ment of English, University of Missouri, Columbia, Missouri.

The Bureau of Medical Economics has prepared an article on the negative argument of this proposition. This article will appear in the Official Debate Handbook. The American Medical Association has also made available for free distribution to debaters the following publications of the Bureau of Medical Economics: A Critical Analysis of Sickness Insurance; Sickness Insurance Not the Remedy; Sickness Insurance Catechism; Some Defects in Insurance Propaganda. Other publications of the Bureau of Medical Economics are being furnished for library loan packages as follows: An Introduction to Medical Economics; Health Insurance in England and Medical Society Plans in the United States; Sickness Insurance, State Medicine and the Costs of Medical Care (Revised Handbook); Collecting Medical Fees; Contract Practice; The Costs of Medical Education; Group Practice; Some Phases of Contract Practice; New Forms of Medical Practice; Prepayment Plans for Hospital Care; Group Hospitalization Contracts are Insurance Contracts; Distribution of Physicians in the United States and Medical Relations Under Workmen's Compensation.

It appears that no one in your state has been designated by Mr. Aly to distribute either the free publications or the library loan packages.

The first printing of the Handbook on Sickness Insurance, State Medicine and the Costs of Medical Care was published by the American Medical Association in December, 1930. Since that time more than 7,500 of these Handbooks have been distributed throughout the United States. An examination of our files shows that since 1932 we have had requests for material on the subject of "state medicine" from the following places in your state: Gainesville and St. Petersburg.

The proposition for debate for students during 1935-36 has been officially announced; unfortunate as the selection may seem, I am of the opinion that it is not only impossible but also unwise to attempt to change the National University Extension Association plans. On the contrary, I believe State Medical Societies should endeavor to assist debaters to secure the most dependable printed material on the subject and an accurate understanding of the attitude of the medical profession as represented in the official actions of the House of Delegates.

Yours respectfully,

R. G. Leland, M.D.,

Director, Bureau of Medical Economics.

To the Editor:

Insulin

The 1935 legislature made an appropriation of $7,500.00 per annum to be used for the purchase and distribution of insulin for the treatment of indigent diabetics. The task of purchasing and distributing the insulin was imposed upon the State Board of Health. The total amount of insulin purchasable with the amount appropriated has been received and is being distributed to the counties in amounts proportional to the population. So far as possible the insulin will be distributed in each county by the County Physician. Where there is no County Physician, arrangements are being made with other local physicians or druggists.

Application for insulin must be made on forms furnished by the State Board of Health and signed by the attending physician and the patient or his parent or guardian. The law provides a suitable penalty for persons obtaining insulin under conditions contrary to the intent and purpose of the law.

The following is a list of County Physicians and others with whom arrangements have been made for the distribution:

County.	Name	Address
Alachua	Dr. J. Maxey Dell	Gainesville
Bradford	Canova's Pharmacy	Starke
Brevard	Dr. H. J. Stevens	Titusville
Broward	Dr. J. A. Stanford	Ft. Lauderdale
Citrus	Dr. L. H. Dame	Inverness
Dade	Dr. Geo. N. MacDonell	Miami
DeSoto	Dr. J. H. Coffee	Arcadia
Dixie	Dr. J. M. Anderson	Cross City
Duval	State Board of Health	Jacksonville
Escambia	Dr. W. A. McPhaul	Pensacola
Gulf	Dr. Thos. Meriwether	Wewahitchka
Hardee	Dr. A. A. Poucher	Wauchula
Hernando	Dr. G. R. Creekmore	Brooksville
Hillsboro	Dr. J. R. McEachern	Tampa
Holmes	Dr. L. H. Paul	Bonifay
Lafayette	Burchfield Pharmacy	Mayo
Leon	Dr. L. J. Graves	Tallahassee
Madison	Davis Drug Co.	Madison
Manatee	Dr. J. W. Henagan	Bradenton
Marion	Dr. E. G. Lindner	Ocala

Nassau—Dr. L. L. Bunker.....Fernandina
Okaloosa—Dr. J. L. Adams.....Crestview
Orange—Dr. H. M. Beardall.....Orlando
Osceola—Dr. H. Brinson.....Kissimmee
Polk—Dr. J. L. Hargrove.....Bartow
St. Johns—Dr. H. E. White.....St. Augustine
Santa Rosa—Dr. Rufus Thames.....Milton
Sarasota—Dr. J. C. Patterson.....Sarasota
Sumter—Dr. W. E. Mitchell.....Bushnell
Suwannee—Home Pharmacy.....Live Oak
Taylor—Dr. C. A. O'Quinn.....Perry
Union—Dr. J. E. Maines.....Lake Butler
Volusia—Dr. E. A. Carter.....DeLand
Wakulla—Crawfordville Drug Co.....Crawfordville
Walton—Dr. C. W. McDonald.....DeFuniak Springs

(Signed) F. A. BRINK, M.D., *Director,*
Bureau of Communicable Diseases,
State Board of Health.

STATE NEWS ITEMS

The following members of the Florida Medical Association attended a summer course in ophthalmology at the Rochester University, Rochester, N. Y., during the last part of July and the first of August:

Clayton Washburn, Jacksonville.
A. B. Connor, Ft. Lauderdale.
G. S. Merrick, Ft. Myers.
M. A. Nickle, Clearwater.
Guy S. Selman, Sanford.

This summer course was given under the direction of some of the outstanding medical men of the country.

* * *

Dr. William M. Rowlett of Tampa has just written a short letter to the Association's office, sending best wishes from Old England. Dr. and Mrs. Rowlett and their debutante daughter, Gregory Rowlett, arrived in England the early part of August, having crossed on the S.S. Normandie. They stayed at the Savoy in London for a few days and then crossed to Paris to be at the Normandy for about a week.

* * *

Dr. Robert Harris of Miami spent the early part of the month vacationing in Western North Carolina. He also spent some time in Chicago, visiting clinics.

* * *

Dr. C. D. Hoffmann of Orlando spent the month of August attending clinics at the Woman's Hospital in New York City and Johns Hopkins in Baltimore. While in Baltimore he was the house guest of Dr. and Mrs. Emil Novak.

Dr. and Mrs. H. V. Weems of Sebring returned on the Normandie, July 8th, from a tour of England, Belgium, Germany, Switzerland and France.

* * *

Dr. Robert Spicer of Miami spent his vacation in Maine recently.

* * *

Dr. and Mrs. H. A. Barge of Miami spent a recent vacation in Birmingham, Ala., Atlanta and Newnan, Ga.

* * *

Dr. Meredith Mallory of Orlando has returned from a trip to Chicago.

* * *

Dr. J. A. Simmons of Arcadia motored to Rochester, Minn., in August, where he spent several weeks attending clinics.

* * *

Dr. and Mrs. C. J. Bible of Miami have returned from an extensive automobile tour of the West. Doctor Bible reports that conditions seem to be improving quite generally.

* * *

Dr. Ralph Gowdy and family of Miami Beach have returned from a two months' stay at Chimney Rock Camp, Chimney, Rock, N. C., where Doctor Gowdy was camp physician.

* * *

The regular quarterly meeting of the Florida Society for Dermatology and Syphilology will be held October 13, in Tampa. Dr. C. A. Andrews of Tampa has been appointed chairman for the meeting.

* * *

Dr. Don C. Eskew of Miami spent the summer attending clinics in Detroit and Cleveland and in doing special work in orthopedics at the Children's Hospital School and Johns Hopkins in Baltimore.

* * *

Members of the Southeastern Surgical Congress met in Century, August 17. Doctors Gerry R. Holden and Edward Jelks of Jacksonville conducted a clinic at the Tuberville Hospital.

* * *

Dr. Bascom Palmer of Miami has returned from an extensive tour during which he visited France, England, Switzerland and other European countries.

Dr. L. Y. Dyrenforth of Jacksonville passed Part III (Exam.) of the National Board of Medical Examiners at Chicago in June and has received its diploma.

* * *

Dr. Carleton Deederer of Miami spent the summer in Columbia University working in chemistry especially with a view towards improvements in treating luetic abdominal adhesions, and later in clinics in plastic surgery.

* * *

Dr. Corbett E. Tumlin left Miami the latter part of August by aeroplane for a visit of clinics in Baltimore, Cleveland, Detroit, and New York. He also spent some time in the North Carolina mountains.

* * *

Dr. and Mrs. Aaron Z. Oberdorfer of Jacksonville returned early in August from a two-weeks' motor trip to New York. During his stay in New York, Doctor Oberdorfer visited the larger surgical clinics in that city.

* * *

The Southern Pediatric Seminar was held this year, as usual, at Saluda, N. C., the last week in July and the first in August. The following report of the Seminar has been received from Dr. J. T. Denton of Sanford:

"Attendance this year was 44, with Florida third in number of attendance, only registering six. Florida usually has the largest number in attendance each year. Those registered this year were: J. T. Denton, Sanford; C. D. Hopkins, Tampa; George C. McClellan, Pompano; R. B. Spires, Defuniak Springs; T. W. Taylor, Sarasota and T. M. McDuffee, Manatee. The interest was the best ever and our Dr. Luther W. Holloway of Jacksonville did the State and his profession well in the lectures he delivered before this assembly. Dr. H. Marshall Taylor of Jacksonville dropped in on us one day and delivered a lecture on 'Ear Infection Common to Beach Bathers.' There is no place one can go for two weeks and get as much pediatric knowledge from as high class doctors and professors from our own Southland schools as this Seminar at Saluda, N. C."

* * *

Dr. T. O. Otto of Miami is spending the month of September in the north. His plans were to visit in Baltimore and to hunt and fish in the Maine woods.

Dr. George M. Green of Daytona Beach and Miss Margaret Dunn of Lancaster, Pa., were married in Jacksonville on September 1st. Dr. and Mrs. Green will reside in Daytona Beach where the doctor practices his profession.

* * *

Dr. Frank Morrow of Miami has returned from Boston, where he studied at the Harvard summer school session. Following this, he vacationed briefly in Canada and visited clinics in Pittsburgh.

* * *

Dr. Nelson Pearson of Miami recently spent a week fishing around Bimini. No report of his "catch" has been received but he did get some interesting color movies.

* * *

Dr. M. C. Wilson of Miami has returned from Baltimore where he was a patient for a while at the Johns Hopkins Hospital. He made it a point, however, to visit the obstetrical and gynecological departments while there.

* * *

Dr. Marvin Smith is expected to return to Miami the latter part of September from Europe, where he has been visiting clinics in London and Vienna as well as vacationing.

* * *

Dr. T. S. Anderson of Live Oak, brother of L. M. Anderson, Lake City, one of the oldest practitioners in the State is still in the Lake City Hospital, receiving treatment for injuries received in an automobile accident on July 23.

* * *

FOR SALE—Deceased physician's library and electrocautery outfit. Address inquiries to P. O. Box 414, Lakeland.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

At the meeting of the Dade County Medical Society held in the Huntington Club Rooms, September 6, the following papers comprised the scientific program:

"X-ray Therapy in Middle Ear and Mastoid Infections," J. H. Lucinian, Miami.

"An Unusual Perineal Burn, with Plastic Repair," J. R. Perdue, Miami.

DESOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The DeSoto-Hardee-Highlands County Medical Society met in Wauchula, at 8 P. M., August 13 with the following members present: Kirkpatrick, Pyatt, Poucher, Highsmith, McKnight, Peacock, McSwain, Brewster, Kayton, Bevis and Martin. Visitors were Drs. W. C. Blake and J. T. Cowart of Tampa.

The question of the Health Unit in DeSoto, Hardee and Highlands counties was brought up and discussed pro and con. Dr. Poucher of Wauchula made a motion that the Society go on record as favoring the Health Units in these three counties. The motion was seconded by Dr. Brewster and carried.

Dr. W. C. Blake of Tampa read a paper on "The Classification and Treatment of Anemia" which was enjoyed by all present. It was discussed by Drs. Brewster, McSwain, Highsmith, Martin, Poucher, Bevis and Kirkpatrick.

Dr. J. T. Cowart read a paper on "Vomiting in Infancy"—a most interesting paper, enjoyed by all. It was discussed by Drs. Brewster, McSwain, Peacock, Poucher and Kirkpatrick.

There being no further business, a rising vote of thanks was given the doctors from Tampa for their excellent papers. The Society adjourned to meet in Wauchula again in September.

ORANGE COUNTY MEDICAL SOCIETY

THE ORANGE COUNTY MEDICAL SOCIETY STANDS 100% PAID FOR 1935. THIS SOCIETY HAS A MEMBERSHIP OF FIFTY-ONE HEADED BY T. M. RIVERS OF KISSIMMEE, PRESIDENT; WILLIAM SINCLAIR, ORLANDO, VICE-PRESIDENT; J. A. PINES, ORLANDO, SECRETARY; AND H. A. DAY OF ORLANDO, TREASURER.

PALM BEACH COUNTY MEDICAL SOCIETY

The regular meeting of the Palm Beach County Medical Society was held August 26. Dr. H. Hamilton Cooke of Miami was guest speaker. He chose "Brain Injuries" as his subject and illustrated his talk with lantern slides and motion pictures. This was an occasion for a "get-together" with doctors from adjoining counties, from Ft. Pierce on the north, Miami on the south, and Clewiston the west. After the meeting, refreshments were served.

WOMAN'S AUXILIARY

TO THE
FLORIDA MEDICAL ASSOCIATION, INC.
State Editor
Mrs. S. M. Copeland
1356 Willowbranch Ave.,
Jacksonville, Florida

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It has long been the custom of the Florida Tuberculosis Association to elect to the honorary vice-presidency, leaders of state organizations and we are pleased to know that this honor was recently conferred upon Mrs. E. W. Veal, state president of the Woman's Auxiliary to the Florida State Medical Association. Such an honor reflects credit to the organization.

Doctors' Wives Cooperate in Observance of Dr. John Gorrie Ice Memorial Week

It is indeed gratifying to note that the doctors' wives throughout the state took such an active part in the observance of Dr. John Gorrie Ice Memorial Week. We trust that sufficient funds were obtained to start a crusade on cancer which will prove beneficial, not only to those making a study of cancer in trying to find a cure for it, but to those afflicted with this terrible disease. We feel that this is a worthwhile movement and should receive the whole hearted cooperation and support of the public. We are glad to have had a part in carrying out the program of this organization of which Dr. Edward Jelks is general chairman, and hope that it may continue to grow until a permanent cure for cancer is found.

What Every Auxiliary Member Should Know:

That a Medical Auxiliary serves the Medical Profession and through it the public. Such service is satisfactory, because it is unselfish. An Auxiliary is always organized with the permission of the Medical Society and should have an advisor or Advisory Committee to direct it. The



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St. Augustine, Florida

Auxiliary should make an annual report to its Society and undertake no new project without approval.

The principal functions of an Auxiliary are: health education, public relations, legislation (reserve force), social.

The laity requires education, but it should be given through the Medical Profession, so there may be relation control of what the public thinks and does in health activities. Most important objectives of an Auxiliary are to direct public thinking and actions in channels the Medical Profession desires and to extend authentic information on health. We support an organization only when we are a member and understand the tasks and objectives and how to accomplish them. An Auxiliary member, therefore, should attend as many meetings as possible, so she may:

1. Understand the purposes and objectives of her Auxiliary.
2. Receive the particular charge given by local, state, southern, national.
3. Receive instruction in how to fulfill that charge.
4. Become informed about:
   a. personal and community hygiene.
   b. administration of local, state, national health.
   c. medical and health laws, local, state, national.
   d. the health of her community.
   e. communicable diseases; their prevention and control.
   f. her health in relation to her community.
   g. general problems of health all should know.
   h. approved educational material; where to obtain it.
   i. the development of the Medical Arts.
   j. why the A. M. A. urges the promotion of Hygeia; how done.
   k. what legislation the Medical Society sponsors; how the Auxiliary acts as a reserve force; what the individual may do.
   l. philanthropic work related to the Medical Profession; service by her Auxiliary; what her Auxiliary is doing; why.
   m. what lay organizations are doing in her community.



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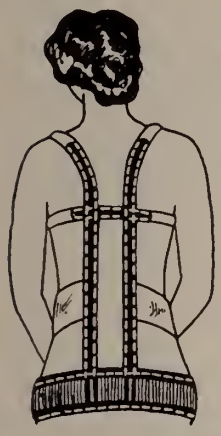
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Take measurements around the hips three inches below the iliac crest.

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Shoulder Brace	2.50
Walking Caliper	17.50
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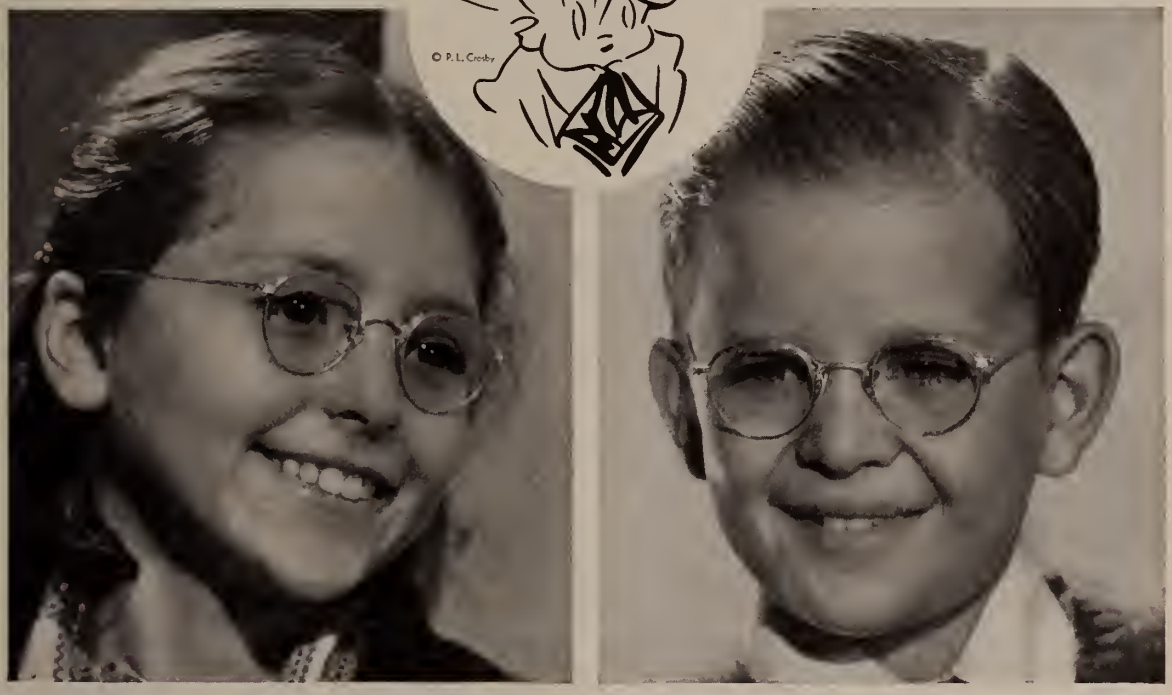
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THE BORDEN DIGEST

Summary of August Issue

Arthritis yields in most instances to treatment by means of a diet of protective foods and heliotherapy. The use of this diet, which includes milk, fruits, green vegetables, and eggs, is described in the interesting paper reviewed in Abstract No. 87.

The cholesterol in milk and eggs is not a factor in the development of human arteriosclerosis, according to Abstract No. 85, in which it is stated that this substance is valuable as the provitamin D and is converted into vitamin D by exposure to irradiation. The lack of vitamin D in most common foods and the desirability of increasing this factor in staple foods, such as milk and bread, is set forth in Abstract No. 86.

In a comparison of spinach and kale with milk as sources of calcium, as reported in Abstract No. 83, it was found that the calcium of kale is utilized almost as well as that of milk, long recognized as the best nutritional source of this valuable mineral. Spinach, on the other hand, was much inferior in this particular respect.

Boiling increases the digestibility of milk, according to the investigation outlined in Abstract No. 84.

Factors influencing milk consumption in a large city are discussed in Abstract No. 88, in which the importance of an increase in the use of milk and dairy products is emphasized.

The relatively low profits on milk, amounting to only one cent per 39 quarts, are revealed by the impartial study summarized in Abstract No. 89.

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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	SECRETARY	MEETINGS				Dues Paid.
		Date	Time	Place	Luncheon?	
Alachua	Harry M. Merchant, M.D., Gainesville.	2nd Tuesday	12:00 Noon	White House Gainesville	Yes.	92%
Bay	Allen H. Miller, M.D., Millville.					80%
Brevard	Bob Schlernitzauer, M.D., Rockledge.	2nd Tuesday		Varies	Yes.	77%
Broward	Robert E. Blount, M.D., Ft. Lauderdale.	Last Wednesday.	8:00 P.M.	Elks' Hall Ft. Lauderdale	No.	100%
Columbia	T. H. Bates, M.D., Lake City.	1st Monday	7:30 P.M.	Blanche Hotel Lake City		100%
Dade	Robert T. Spicer, M.D., Miami.	1st Friday	8:30 P.M.	Club Room Huntington Bldg. Miami	Occasionally.	98%
DeSoto-Hardee-Highlands	L. W. Martin, M.D., Sebring.	2nd Tuesday	8:00 P.M.	Varies	Yes.	100%
Duval	Charles B. Mabry, M.D., Jacksonville.	1st Tuesday	8:15 P.M.	Mayflower Hotel Jacksonville	No.	78%
Escambia	J. M. Hoffman, M.D., Pensacola.	2nd Tuesday	8:00 P.M.	Board of Health Building Pensacola	No.	89%
Hillsboro	John S. Helms, Jr., M.D., Tampa.	1st Tuesday	8:00 P.M.	Tampa Municipal Hospital Tampa	No.	92%
Jackson	Lewis Pierce, M.D., Marianna.	2nd Tuesday	7:30 P.M.	Hotel Chipola, Marianna	Yes.	92%
Lake	W. L. Ashton, M.D., Umatilla.	1st Thursday	12:30 P.M.	Eustis	Yes.	95%
Lee	H. Quillian Jones, M.D., Ft. Myers.	3rd Friday	7:30 P.M.	Lee Memorial Hospital Ft. Myers	No.	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	O. G. Kendrick, M.D., Tallahassee.	Quarterly	3:00 P.M.	Varies	Yes.	82%
Madison	Geo. O. Davis, M.D., Madison.					100%
Manatee	W. D. Sugg, M.D., Bradenton.	3rd Tuesday	7:00 P.M.	Whitfield Country Club Bradenton	Yes.	75%
Marion	Richard C. Cumming, M.D., Ocala.	3rd Thursday	12:30 P.M.	Marion Hotel Ocala	Yes.	100%
Monroe	W. R. Warren, M.D., Key West.	1st Sunday	9:00 P.M.	Varies	Yes.	100%
Orange	John A. Pines, M.D., Orlando.	3rd Wednesday	8:30 P.M.	Varies	No.	100%
Palm Beach	Lloyd J. Netto, M.D., W. Palm Beach.	4th Monday	8:00 P.M.	Good Samaritan Hospital W. Palm Beach	No.	100%
Pasco-Hernando-Citrus	John J. Bourke, M.D., Dade City.	2nd Thursday	7:00 P.M.	Varies	Yes.	100%
Pinellas	O. O. Feaster, M.D., St. Petersburg	1st Friday	8:00 P.M.	Assembly Room, 5th floor, P. & L. Bldg. St. Petersburg	No.	95%
Polk	J. R. Boulware, Jr., M.D., Lakeland.	2nd Wednesday in Feb., Apr., June, Aug., Oct., Dec.	1:00 P.M.	Lakeland	Yes.	100%
Putnam	E. W. Warren, M.D., Palatka.	2nd Thursday	7:00 P.M.	James Hotel, Palatka	Yes.	86%
St. Johns	John L. Bennett, M.D., St. Augustine.	3rd Tuesday	8:30 P.M.	Varies	Yes.	100%
St. Lucie-Okeechobee-Indian River-Martin	E. B. Hardee, M.D., Vero Beach.	3rd Thursday	8:00 P.M.	Varies	Yes.	79%
Sarasota	J. E. Harris, M.D., Sarasota.	2nd Tuesday	8:30 P.M.	Varies	Occasionally.	93%
Seminole	J. T. Denton, M.D., Sanford.	2nd Monday	7:00 P.M.	City Hospital Sanford	Yes.	100%
Sumter	W. E. Mitchell, M.D., Coleman.	2nd Tuesday		Varies	No.	100%
Taylor	C. A. O'Quinn, M.D., Perry.	Last Friday	8:00 P.M.	Dixie-Taylor Hotel Perry	Yes.	100%
Volusia	Hugh West, M. D., DeLand	2nd Tuesday	7:30 P.M.	Varies	Yes.	87%
Walton-Okaloosa	A. G. Williams, M.D., Lakewood.	3rd Thursday	8:00 P.M.	Varies	Occasionally.	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



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THE JOURNAL
—— OF THE ——
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VOLUME XXII
NO. 4

Jacksonville, Florida, October, 1935

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American Medical Association, Kansas City, Mo., 1936.
Southern Medical Association, St. Louis, November 19-22, 1935

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(1) J. Amer. Med. Assn. 97, 1890 (1931)

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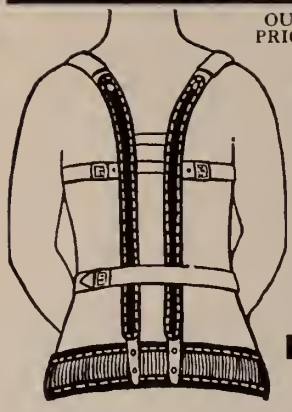
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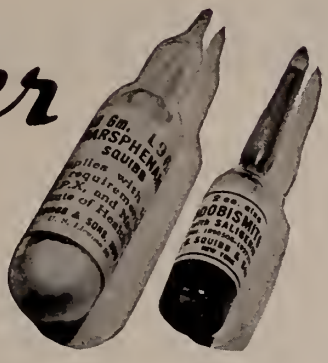
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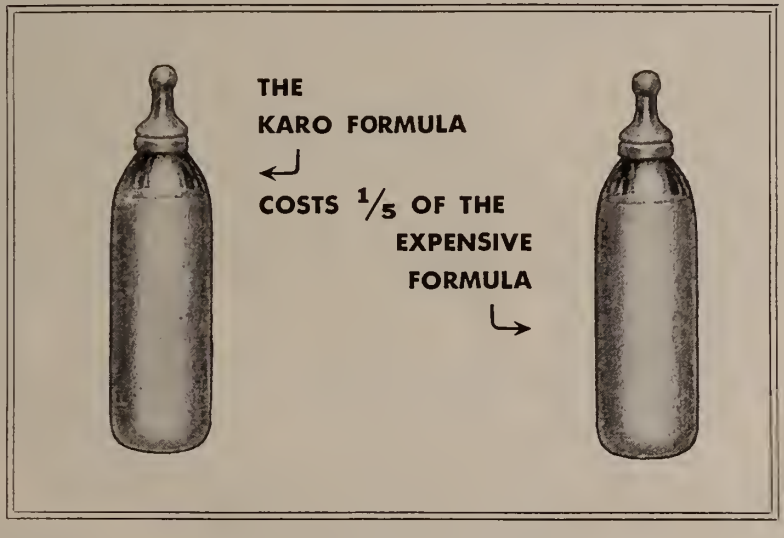
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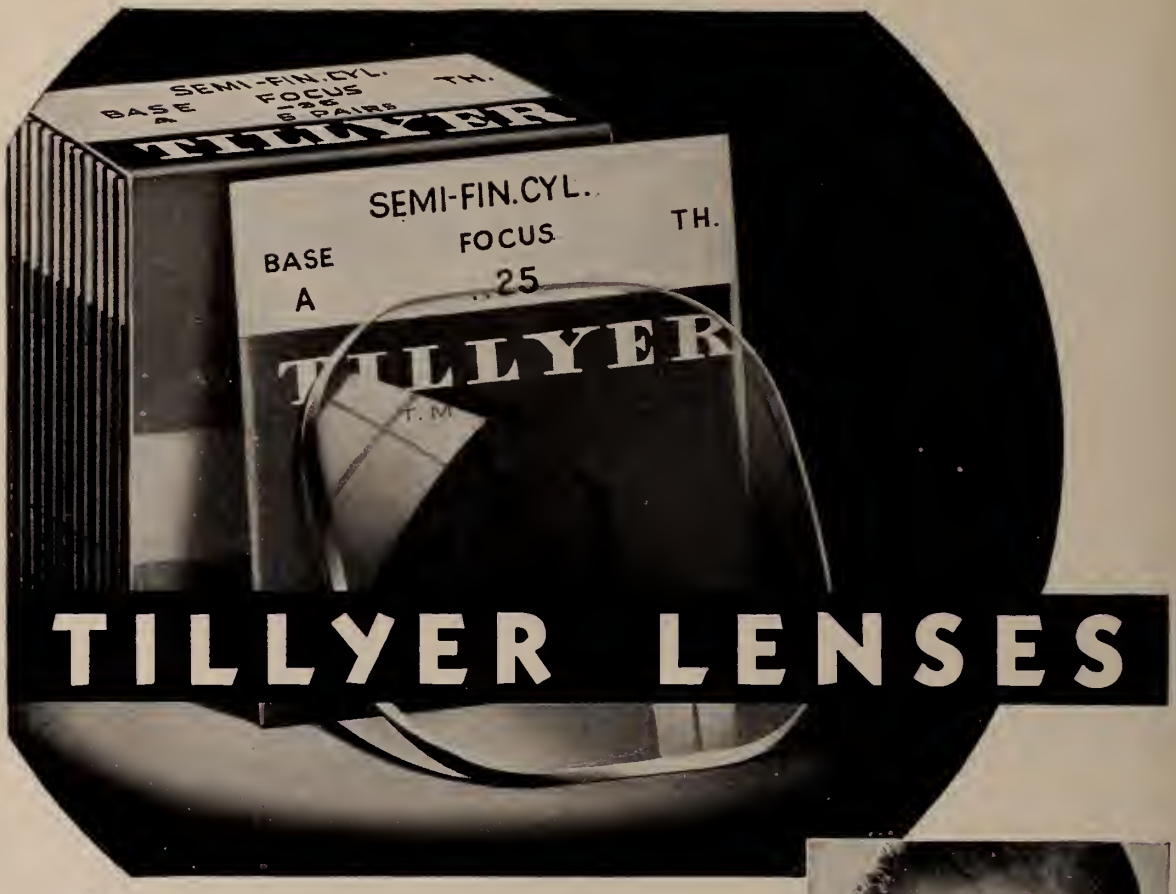


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A DISCUSSION OF A GROUP OF COMMON SKIN DISEASES*

CHADBOURNE A. ANDREWS, M.D.,
Tampa.

The common skin diseases of Florida possibly vary somewhat, depending on the locality in which the observer lives. Those who may discuss this talk may have some problems that I do not encounter, and the time allotted does not warrant discussing fully the four conditions that I think are common to the medical observer.

A similar talk was given on Hospital Day several months ago at the Tampa Municipal Hospital entitled "Florida Sores a Misnomer." Ever since our Florida boom, to my knowledge, and possibly further back, "a Florida Sore" has been an expression in common usage, although I think it was coined by the medical men who flocked to this State at that time.

Many of you no doubt have had inquiries from medical men outside our State asking: "What is a Florida Sore"? That has been my experience, and no less an authority than Dr. O. S. Ormsby had a patient wintering in this State who having had such a diagnosis made, wrote him for an opinion.

During our boom period at least six families, who had moved into our State as permanent residents, were ready to close out their interests and return home because their medical advisors, not being familiar with these conditions which I will mention in a moment, had diagnosed them "Florida Sores." They had told these patients that they would continue to have this condition until they left the State. I ask you if this is good advertising for the State? In the future let us eliminate such a term, as also we might "Athlete's Foot," coined by the Absorbine Junior Company, which you know refers to types of ringworm.

The conditions that I propose to bring to your attention today are, larva migrans, ringworm infection, scabies, and impetigo. Impetigo, being of streptococcic and staphylococcic origin, I think merits being discussed last, as it is almost always superimposed on the other three.

LARVA MIGRANS

Larva migrans is essentially a semitropical, and tropical disease, and has been recognized for many years. However, the first complete scientific discussion was published by Dr. Kirby-Smith of Jacksonville, Florida, and Dove and White, workers in the United States Public Health Service. They proved definitely that a microscopic nematode was the causative factor, and shortly after this report, Shelmire of Dallas, Texas, in a paper presented at the American Medical Association Meeting held in Rochester, Minnesota, pointed out that the cases seen in the South originated in the larva of the cat and dog hookworm.

The disease has two stages. First, at the site of inoculation appears a papule, typically an insect bite, which varies in duration from one to several days, and in one case seen last year lasted nearly thirty days, with only three or four typical "lines." The second stage is a migrating one, and this is the one usually presented for medical attention. Starting as a line from the papule which is narrow, and later erythematous and vesicular, or both, it is produced by the migration of the parasite. It may be straight, or in varying configurations; the severity of the condition and symptoms depends on the number of parasites. Itching and stinging is present and in extensive involvements is sometimes unbearable.

The abode of the parasite is soft, damp sand, and during our rainy season the largest percentage of cases are seen, and a large proportion of these are inoculated at the beaches. Extensive cases are also seen in mechanics, such as plumbers, carpenters, and automobile workers, who occasionally become infected while working under cars and buildings.

The best treatment, in my opinion, is refrigeration either in the form of carbon dioxide snow or ethyl chloride. This is quite satisfactory for the patient with few lesions, but when the lesions are extensive, it is sometimes worse than the dis-

*Read before the Sixty-second Annual Meeting of the Florida Medical Association, Ocala, May 13-15, 1935.

ease. Many other methods are recommended but in my hands refrigeration has been the most satisfactory one, and the individual who can discover a treatment that is safe, painless and quick in action, will accomplish the thing that at present is in the realm of speculation.

Ringworm

Ringworm is a general term for the dermatological condition produced by vegetable fungi. The classification advanced by Sabourand in 1892 is still accepted by most dermatologists, and since several regions of the body present fairly distinctive diagnostic pictures, text books discuss them separately; for example, ringworm of the body, scalp, beard, et cetera. Many fungi have been isolated, and new ones are constantly reported. The one that I particularly want to call to your attention is the Epidermophyton. It is recognized as causing eczema marginatum, (jock-strap or athletic itch), and conditions of the feet and occasionally the hands, which conditions one dermatologist stated, I believe at one of our Southern medical meetings, constituted over fifty per cent of his work during the summer months.

Eczema marginalis starts on the inner thighs, first as a papule. Soon grouping occurs in a crescentic outline until sometimes the entire inner thighs and perineal regions are involved, and without treatment will continue indefinitely, fading as cold weather appears. It may manifest itself all over the body. I have seen one case on a bald head where the lesions were proved by the microscope.

The lesions of the hands and feet are readily divided into three groups: the acute vesicular pustular; the chronic intertrigenous; and the hyperkeratotic of the palms and soles. The acute vesicular pustular may have few or many vesicles, later large blebs, and has been called anything from "poison ivy" to "too much acid in the system". Always between the toes is a dirty white, soggy disquamation. A secondary pus infection is always superimposed, and at this time I want to call to the attention of those interested in this subject an article by James H. Mitchell, in the Journal of the American Association, on April 6, 1935, entitled "Streptococcis Infection Simulating Ringworm of the Hands and Feet." While I do not wish to be controversial, I would divide the treatment into the acute and the chronic types. To treat the acute form other than with soothing preparations will defeat a cure. Calamine lotion or similar preparations until the acute symptoms subside, and then mild keratolytics, gradually increasing their strength if need be, seem in many cases to be quite satisfactory. Salicylic acid, if not abused seems, at least in my judgment, very satisfactory. I think, however, the last word in treatment has yet to be found.

The chronic intertrigenous type, like the poor, and one might add taxes, are always with us. A dusting powder, having as a base sodium thiosulphate, potassium permanganate soaks, salicylic acid in ointment form, and judicious care of the feet, such as Joslyn recommended to diabetics who had ringworm of the feet, will get results.

Acarus Scabiei

In the twelfth century an Arabian author, Avenzoar, remarked that the itch was caused by a small animalcule, but seven centuries elapsed before its cause was actually demonstrated. About the middle of the sixteenth century an English physician, Thomas Monfit, made the same remark but it remained for Bonomi, in collaboration with Cestoni, to demonstrate the acarus in the vesicles, and recommend sulphur. The etiological factor was then forgotten although sulphur as a curative remedy was continued.

In 1824, Renucci, a Corsican student, hearing his Professor Allibert deny that the acarus was the cause of scabies, dramatically extracted a mite from his own skin, thus settling a question in debate for seven centuries.

Scabies is a cutaneous disease due to the invasion of the skin by the acarus scabiei characterized by itching and lesions of a papular vesicular and pustular type, predominantly upon the fingers, hands, axillary folds, lower abdomen, and genital and anal regions. The first evidence is itching caused by the parasite within the cutaneous tissue, and examination reveals a few papules and vesicles, as the condition gets progressively worse. By the time the patient seeks medical advice, excoriations, papules, vesicles and often pustules, are seen all over the body, especially on the hands, between the fingers, wrists, region of the elbow, at the axilla, lower abdomen, the genitalia, cleft of the nates, inside the thighs and occasionally about the ankles and feet. In women I always inspect the region about the nipple, and in men the genitals. In addition to these lesions is the gallery, which is the tiny tunnel, one-eighth to one-half inch, made by the female parasite, and is seen as a tortuous, slightly

elevated, line noticed best on the wrists and between the fingers. These lesions are rarely seen on the face except in infants, when the condition is invariably diagnosed as infantile eczema. The eruption is very pronounced especially in the careless and unclean. This has led to various names being given to this condition such as Norwegian itch, Italian itch, Cuban itch, et cetera.

In certain occupations, such as stone-cutters, bricklayers, polishers, painters, et cetera, the hands, from the character of the work and the frequent washings necessitated, are, as a rule, the seat of very few lesions. Animal scabies are similar to the human and may be conveyed to man. Scabies may be conveyed by contact, such as towels, toilet articles, tools and shaking hands, but the most common way is by sleeping with the infected, or occupying a bed in which an infected person has slept. The female parasite is the one that invades the integument, but she does not invade the rete. As she burrows she deposits eggs, and finally dies in the integument. The female is about one seventieth of an inch long. The male is one-third less in length, and does not invade the skin, but remains on the surface. The larva develops from the egg in about five days, and is about twelve days reaching adult life. Diagnosis is usually easy, and in cases of doubt a microscopic examination will confirm a diagnosis. The disease is readily cured under proper medication but one should not overtreat because a dermatitis from sulphur does occur, which is often mistaken for the original condition.

Impetigo

In the early days of dermatology the formation of pus in the skin was regarded as a special disease to which the term impetigo (from Impitere) was applied. In 1864, Tilbury Fox rescued the term when he applied it to the well-defined symptom complex which he called Impetigo Contagiosa. Many different forms have been described, sometimes with special reference to the infecting organism as Sabourand's streptococci contagiosa, and Bockhart's impetigo due to staphylococci, and now the different forms of impetigo may be regarded as part of one clinical condition, and the term may be used quite as well without qualifications to describe the pustular and vesicular lesions which are produced in the skin by infection with the common pus-producing organisms.

The lesions may be vesicles or pustules from the start, either flacid or tense. In a few days rupture takes place, leaving an abraded red surface, from which is an exudation of serum and pus, which dries into crusts. Resolution takes place at this time and a temporary red stain is left. The disease being auto-inoculable and hereto-inoculable spreads rapidly wherever there is an abrasion, and thus the course is indefinite, the lower limit being ten days, and the upper sometimes months, without proper attention. The majority of cases are children since abrasions are common, the sites of predilection being the face, hands and axillae, and a generalized infection is not uncommon.

In large out-patient clinics, many cases of impetigo are associated with the presence of pediculi upon the scalp, and many cases of impetigo circinata have been mistaken for ringworm. Epidemics are not uncommon in schools, public institutions, and in obstetrical wards it is sometimes so serious as to close that department. This type is sometimes called pemphigus neonatorium and must not be confused with true pemphigus. The proper treatment should correct this condition in an average of two weeks. Five per cent ammoniated mercury is used in adults, and in children half this strength is sufficient. In the so-called "Barbers' Itch" impetigo of the face of adult males, hot 1:2000 bichloride of mercury packs three times a day are excellent adjuncts.

DISCUSSION

Dr. J. J. Saxton, Tampa:

I wish to congratulate the speaker on his terse, practical presentation of a subject which might have taken a much greater time.

The use of the term "Florida Sore" certainly is to be discouraged. A paper calling attention to its unscientific, and at times detrimental, use is most timely. I doubt that the term is used by any of our members, but if the paper stresses the point, and causes the physicians of the State to impress the fact on their patients that there is no such condition as that, scientific medicine will have been served.

Larva migrans is practically a tropical and a subtropical disease, though a similar condition caused by a fly larva is obtained as far north as Canada.

The papule at the point of entrance of the larva is not sufficiently characteristic for a diagnosis in that stage, though it may be suspected and a fairly certain diagnosis made by inspection and a careful history. But the elevated linear

erythema extending from the papule soon makes the diagnosis certain. Many patients with well developed larva migrans come to the dermatologist with a diagnosis of ringworm. The injection of chloroform, incision and application of iodine, and the use of the actual cautery, have all been advocated and tried. The methods all have the same inherent weakness, that is the lack of ability on the part of the observer to locate the exact position of the offending organism.

Ringworm as a problem is on a parity with syphilis. The diagnosis and treatment require knowledge, experience and judgment. The discussion of this subject alone could well take up the entire time of the State medical meeting.

It seems incredible that so obvious a cause of disease as that of scabies should so long escape observation, and then when finally demonstrated should be so strenuously denied. It is not strange that so many cases of scabies should come to the dermatologist with the diagnosis of "too much acid in the blood", as the diagnosis of scabies presents difficulties to the experienced dermatologist. The treatment requires care and thoroughness.

Impetigo contagiosa has yielded both streptococcus and staphylococcus as well as streptococcus hemolyticus, the latter probably being the cause of nephritis in or following the pyodermias.

Whitfield demonstrated that the demodex folliculorum carried the organisms of impetigo. Thus the obscure places of dermatology are illuminate.

Dr. J. L. Kirby-Smith, Jacksonville:

Dr. Andrews has given us an interesting account of the common parasitic skin diseases that are prevalent here and in other States. I wish to make a few remarks about creeping eruption.

Larva migrans or dermal miasis is a very uncommon infection of the skin with fly larva. However, creeping eruption is a very common itchy skin disease seen in the coastal parts of the Atlantic Seaboard section, and too in a few places on the Gulf and southwest States. It is not a tropical disease.

Dr. Andrews mentions that Bedford Shelmire of Dallas, Texas, pointed out that creeping eruption originated from the larva of cats' and dogs' hookworm. I wish to correct this statement, as a year or so prior to that, to be exact, in 1927, I presented to the American Society of Tropical Medicine at the annual meeting at Boston, Mass., a report of the work of myself and associates, giving in full the cause of creeping eruption, *i.e.*, the larva of the ancylostoma Brazilience from hookworm-infected cats and dogs, the disease transmitted to humans by contact with wet polluted sandy soil. As a matter of fact, Bedford Shelmire's report, as mentioned by Dr. Andrews, was merely to corroborate some of the work that my associates and myself have done, and particularly the former, in producing experimentally creeping eruption on the skin of man.

About the matter of impetigo: I suppose you should know that impetigo is a specific contagious skin disease due to the inoculation of the skin by the staphylococcus and at times the streptococcus, and I should add that it is somewhat self-limited in its course.

Itching is more or less a symptom of all our common parasitic skin diseases, and generally such a condition would be expected to be followed with skin infections. However, we do not denominate these infected skin diseases as impetigo, though there may be some impetiginous element present.

Dr. Andrews mentions the matter of treatment of creeping eruption. From my years of experience with this disease I say today, as I have said a number of times in the past, a cure can always be obtained by proper understanding of the nature of the disease, a study of each particular infection, using judgment as to the location of the parasite and a complete refrigeration. With multiple lesions time and patience are required, however. As I see the matter, the treatment of multiple creeping eruptions should be planned as in the matter of any operation.

In closing my remarks in the discussion of Dr. Andrews paper, I agree with what he says regarding "Florida Sores". As a matter of fact we do not have any skin disease, or as for that, any disease peculiar to Florida. During my years of experience in Florida, on many occasions I have had to correct inquiries about the matter of Florida skin diseases. After the south Florida hurricane, and too, during the boom days, individuals were careless about their skins and ordinary parasitic skin diseases became infected with pus cocci by scratching itchy skin conditions. On returning north they claimed they had Florida Sores. Northern colleagues have inquired what particular skin diseases do you in Florida consider peculiar to your State? This is unfortunate and misleading to say the least. As you

know, creeping eruption, ringworm disease in all its forms are not peculiar to our State.

Dr. J. T. Denton, Sanford:

I have had twenty-odd years of treating larva migrans and today my method of treatment costs me one cent in comparison to probably fifty cents by ethyl chlorid. Usually about one or two applications is sufficient to cure the disease. I have enjoyed reading many papers on larva migrans and they have never brought out this line of treatment.

First, larva migrans is a disease of the intraderma. This creeping eruption or larva travels within the layers of the skin. Now, you know that when you use carbolic acid to wash your hands with, you immediately or presently turn around and wash them with alcohol. You counteract the effects of your carbolic acid. Why not do the same thing on intradermal diseases such as larva migrans?

I have had numerous cases in my office caused by picking strawberries, the hands infected with them. I tell these patients to go and buy a small amount of carbolic acid and a small bottle of alcohol, 70%, go home and every day put on new applications around where these new infections of the larva migrans go. Where he travels today he won't be tomorrow. No use to touch there; he is not there. He is in a new field. Always touch with acid beyond your recent tract and then you will cover the infected areas. Then counteract after it turns white, with alcohol, and you will have killed your larva.

Dr. W. W. McKibben, Miami:

This has worked itself up to becoming an indignation meeting on "Florida sores." The same condition is found almost anywhere. In California they are called "California sores." In Massachusetts we called them "Massachusetts sores." In Borneo they would be called "Borneo sores."

It is interesting to note the geographical distribution of this disease, impetigo. The further north you go, the nearer the upper part of the body the disease manifests itself. In Massachusetts we saw it largely on the exposed chin and around the mouth; mainly a facial infection. Dr. Andrews spoke about its being on the upper part of the body, in the axilla and around the chest. Down in Miami, it is mainly on the exposed legs and around the ankles.

We have practically overlooked a very important etiological factor—the mosquito. I became interested in mosquito control because I think they incite, particularly among children, some of our skin diseases, such as impetigo. We have been working for two years on a very definite campaign against the mosquito. Two years ago, I spent one morning on Key Biscayne with a group of engineers. Before control was accomplished, there was such a great number of mosquitoes that it was almost impossible to remain. Coming back, I had a call to the southern part of the city, and found five children with impetigo. Two of the children were asleep; I went into the sleeping room and found many mosquitoes.

I collected specimens and compared them with the ones collected down on the Keys; they were of the same species—taeniorrhynchus, or salt-marsh mosquitoes. All of the children were violently scratching and their infected nails were extremely dirty.

I have felt, from that time on, that one of the most important treatments for impetigo is the manicuring of the nails in children. Use plenty of soap and water, and for the psychological effect, I recommend germicidal soap with a stiff new nail brush. I have found that mothers will use this when not inclined to use ordinary soap and water. These infections are usually secondary to a traumatic abrasion of some kind, or prickly heat, but mostly to mosquito bites. By taking care of the nails any slight abrasion of the skin, particularly where there are crusts, for the organisms are under crusts, we can do a great deal toward preventing the continued spreading of such conditions. There are numerous things which we can use to soak off the crusts, such as plain peroxide; however, ordinary soap and water will clean satisfactorily. If you stop the itching with phenol in calamine lotion, you have helped a great deal. Ammoniated mercury, 5%, will be effective in healing the lesions. Ten per cent seems to be too strong on children.

Dr. J. W. Alsobrook, Plant City:

We fortunately don't see very many bad cases of larva migrans at this time. Thirty years ago larva migrans was so severe that a negro accustomed to going barefooted had the soles of his feet clipped around the edges and they fell off on the floor. That is when you get larva migrans deluxe.

The carbolic acid treatment was used thirty years ago and found ineffective.

I had one patient whom I had treated for four

or five months who went to Seattle, Washington. He had one left in the bottom of his foot. The doctor there wrote me a very pathetic letter asking what in Hell this man had and what in Hell to do for it.

The treatment of larva migrans has gone all over the whole line, and there is nothing to my mind so effective as ethyl chlorid used for two minutes. There may be slight frostbite and a little slough but it will come nearer killing it than anyhing else.

Dr. Chadbourne A. Andrews, Tampa (Concluding):

I think this has been a rather interesting discussion. What I tried to do was show you four different types of conditions that are distinct entities, and sometimes, if the observer is not careful he is liable to confuse them.

I am not going to try to discuss any of the remarks of the speakers.

I think all of you are familiar with this sort of thing, and if I have done one thing, which I hope I have, to convince you that it would be much better not to call these lesions "Florida sores," I think that whatever criticism I may have heaped upon me, I can take.

OSTEOCHONDRITIS DEFORMANS JUVENALIS COXAE*

J. H. Branan, Lt. Comdr. (M.C.), U.S.N.
U. S. Naval Hospital,
Pensacola.

While of comparatively recent recognition this condition has been variously designated as Legg's; Legg-Perthes'; Calve-Legg-Perthes' or Perthes' disease; coxa plana; pseudo coxalgia; epiphysitis of the femoral head; quiet hip disease; flat head femur. Osteochondritis deformans juvenalis seems a most appropriate designation.

Legg of Boston reported five cases in 1909. Perthes of Tubingen, about 1910, described its clinical and pathological phases in a series of papers while Calve coincidentally reported cases. Twenty-four cases were observed after trauma incident to manipulative reduction of congenital hip joint dislocations.

Traumata affecting bone and cartilage during a period of unusual growth, which results in circulatory disturbance and is followed by regeneration and adjustment, are factors which are generally conceded in its etiology. Some observers have isolated staphylococci from cases while others deny infectious foci. Phimester operated upon one patient and obtained evidence of an associated infection of low virulence but failed to isolate any organisms by cultural and animal inoculation methods.

A common pathogenesis is suggested by histopathological findings involving bones located in situations especially liable to injury during athletics, play and occupational strains and reported as:

a. Osteochondritis deformans juvenalis coxae.
b. Juvenile deforming metatarsophalangeal osteochondritis. (Frieburg's infraction of the metatarsal head.)[1]
c. Osgood Schlatter's disease of the tibial tubercle. (Rugby knee).
d. Kohler's disease of the tarsal scaphoid.
e. Calcaneal apophysitis.
f. Scheuermann's vertebral epiphysitis.[2]
g. O'Connor's osteochondritis deformans juvenalis of the olecranon.[3]
h. Osteochondritis dissecans of König.

The center of ossification for the head of the femur appears about the end of the first year and unites with the shaft at the eighteenth year.

In 1909 Legg[4] offered the theory that trauma caused a disturbance of the circulation with blocking of some of the epiphyseal vessels to this center. Atrophy and necrosis in the center followed. The blocked off circulation was diverted to the diaphyseal vessels of the neck of the femur. The resultant hyperemia favored hypertrophy, thickening and modification in the shape of the neck. Later growth changes and pressure from weight bearing changed the angulation of the neck with the shaft and flattened the head of the femur.

Thus, during the progress of the disease, there are two more or less well marked stages.[5]

First—That of epiphyseal destruction in which the epiphysis becomes flattened, thinned out, divided into two or more portions and may almost disappear leaving a thickened shortened neck with marked reduction of its angle with the shaft of the femur—*i.e.*, coxa vara.

Second—A stage of regenerative repair during which the epiphyseal line approaches the horizontal; the femoral neck is widened; projects chinlike internally; retains its lessened angle to the shaft and is capped by a flattened head whose bone center is fragmented.

The age incidence is from five to ten years

*Read before the Escambia County Medical Society, Pensacola, February 12, 1935.

with the majority of cases presenting toward the end of the first decade of life. Its occurrence after fifteen years is unknown. Cases first picked up at a later age are those either not coming under observation during or were not recognized in the early stages. The ratio of boys to girls in one series of cases was four to one.

In the early stage the involved joint presents the picture of an acute synovitis and contains an excess of fluid. In Phimester's patient the articular synovia had preserved its normal sheen. The involved epiphyseal center had broken down into a cavity filled with granulation tissue, necrotic debris and small sequestra. These changes suggested an old pyogenic infection with destruction of the involved area. Up to this stage the process appears limited by the wall of cartilage that surrounds the center of ossification.

This layer of cartilage is not pierced by nerve fibers which accounts for the lack of pain while the involved area is limited to the center itself.

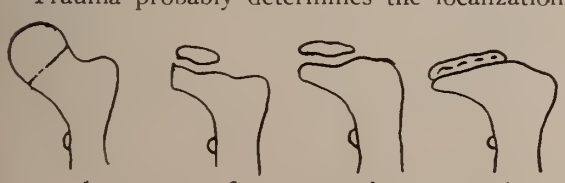
During the second stage, destructive and regenerative changes bring about clinical symptoms and the patient under observation. The head of the femur is flattened and bulges beyond the margins of the acetabulum. Secondary changes are evidenced by an irregularity and increase of cartilage in the acetabulum.

In advanced cases necrosis extends through the epiphyseal cartilage plate into the cancellous structure of the neck, involves the head producing fragmentation and finally destruction of the cartilage and synovial lining of the joint. Ankylosis, of greater or less degree, follows. Staphylococci have been isolated from these necrotic areas.

The history of trauma obtained in the majority of cases with irregular fever support Phimester's findings and conclusion that low grade infection was indicated in his case.

Nathaniel Allison,[5] however, holds that, in the larger number of cases, there is no evidence of local or systemic infection and he separates the cases of epiphysitis due to infection from those classed as Perthes' disease.

Trauma probably determines the localization of an infective process in this disease just as it plays a part in osteomyelitis elsewhere.



Diagrammatic Representation of Pathology[7]

1. Normal relationships.
2. Growth disc approaching horizontal position.
3. Widening of neck and flattening of head of femur.
4. Excessive flattening of head with fragmentation of center. Lessened shaft angle.

X-Ray Findings

There are no demonstrable changes in the early stages.

In the intermediary stage flattening of the head with alteration in form of the acetabulum to conform to the head occurs. Decreased density of the adjacent pelvic bones presents.

As the process advances atrophy and fragmentation of the head appear—the neck becomes thickened, broadened and stunted; the epiphysis irregular in outline and approaches the horizontal while the articular outlines are obscured.

In the stage of regeneration the density of the head and neck are restored to normal but flattening of the head and coxa vara persist.

The onset of this disease during the first decade of life, its excellent prognosis when recognized and treated during its early stages, its confusion with tuberculosis of the hip in a more advanced period of development seems to justify the presentation of an advanced case in which shortening, limp, limitation of motion, ankylosis and inability to perform heavy duty are sequellae to regenerative changes.

Symptomatology.

With or without a history of trauma and low grade fever a mild synovitis of the hip joint presents. Sooner or later limping with a varying degree of pain referred to the hip joint or knee is followed by limitation of abduction and internal rotation. No thickening of the periarticular tissues occurs. The thigh and gluteal muscles about the joint atrophy from disuse rather than as a result of the joint disease. With involvement of the epiphyseal cartilage and head or neck of the femur measurable shortening may be determined.

These symptoms subside after a period of six to eighteen months in the untreated case, regeneration changes ensue and function improves with persistence of limp, limitation of abduction and internal rotation and variable shortening.

Recurrence of symptoms is very apt to follow heavy work.



DIAGNOSIS

In early stage cases symptoms of an acute synovitis of the hip joint with or without a history of trauma presenting in a child under ten years of age are suggestive of this disease. A little later x-ray findings are characteristic when tuberculosis of the joint is ruled out. In advanced cases x-ray findings are necessary for a positive diagnosis.

DIFFERENTIAL DIAGNOSIS

1. *Tuberculosis of the Hip Joint.*

Symptoms are more severe, constant and progress more rapidly. A temperature rise is present over a prolonged period. Muscle spasm and night cries are prominent. Radiographs visualize osseous rarefaction, necrosis and atrophy and later articular and periarticular inflammatory processes. Abscess formation, sequestra and ankylosis are sequellae. The tuberculin test is not conclusive nor reliable. Operation, biopsy or inoculation of a guinea pig will only occasionally be necessary for diagnosis.

2. *Epiphyseal Separation of the Femoral Head.*

This injury most frequently presents when a child in arms throws its weight forcibly backwards, thus hyperextending the thigh. The taut Y ligament acts as a fulcrum to impinge the epiphysis against the anterior lip of the acetabulum. A fracture along the epiphyseal line results. Coxa vara develops later in unrecognized and untreated cases.

3. *Slipping Epiphysis.*

During the course of progress in a case of Perthes' disease and most commonly near ten years of age a patient may complain of pain in the affected hip joint over a period of months. Tuberculosis may be suspected until x-ray examination notes an intracapsular fracture. This fracture not infrequently follows additional trauma.

The upper center of ossification of the femur is intracapsular. Stereoscopic x-ray examination to include both hip joints with the femora in the same relative positions is most advantageous.

4. *Congenital Dislocation of the Hip.*[6]

A superficial resemblance exists in the presence of a limp dating from the period at which the child began to walk.

This condition is more common in girls. If unilateral there is a decided limp while, if bilateral, a waddling gait obtains. The limb may appear to become suddenly shorter as the child puts its weight on that side, and a dropping downward of the opposite gluteofemoral fold constitutes Trendelenburg's sign. In the upright position lordosis and scoliosis toward the affected side are noticeable.

In prone position there are both visible and measured shortening; the greater trochanter is raised above the level of Nelatin's line and, if the dislocation is complete, the head of the femur is palpable on the dorsum ilii.

The limp is painless and abnormal mobility instead of restricted motion is present. X-ray examination is conclusive.

5. *Congenital Coxa Vara.*[6]

This is a rare condition. It may occur alone but is most often associated with congenital dislocation of the hip joint. The neck of the femur is shortened and the angle with the shaft decreased, at times even to a right angle. Motion of the hip joint involved is restricted and "Trendelenburg's sign of dislocation" is reversed, *i.e.*, the opposite gluteofemoral fold is raised not lowered as in congenital dislocation of the hip joint. X-ray examination will clear up the diagnosis.

Treatment

1. *Early Cases.*

Rest in bed without fixation. Relief of superincumbent weight is most important. A better circulation is obtained without fixation. At this stage there is no destruction present. Heliotherapy or ultraviolet radiation is just as valuable as in other joint diseases.

Treatment directed to the elimination of systemic and focal infection, when present, is indicated to forestall possible localization in the involved epiphysis.

A high calcium, high vitamin diet is indicated. Rachitis has been accorded a place in the etiology of certain cases. Massage, diathermy and infra red light are indicated for their respective effects.

Graduated active rather than passive bed exercises after acute symptoms subside followed by the use of a caliper hip splint to take off weight bearing will insure cure after a period of from six months to three years.

X-ray checks of the progress toward healing are necessary during the course of treatment.

2. *Advanced Cases.*

Plaster spica of pelvis and hip joint to permit free use of knee placing thigh in extreme abduction tends to assure a spherical shaped head with better end result. However, if x-ray examination determines involvement of the articular cartilage of the joint with probable ankylosis resulting, then a plaster of paris cast from pelvis to foot with leg straight down and knee slightly flexed and so maintained until x-ray findings show a maximum attainment of regeneration, will be preferable.

Fixation for from eight to twelve months at least is usually required.

Outcome

Recognized and treated early before destructive changes occur recovery without sequellae is the rule.

After disintegration occurs the head of the femur becomes misshapen and regeneration extending over a period of from one to three years produces mushrooming.

After osteomyelitis with involvement of the joint cartilage, ankylosis of varying degree ensues with permanent disability. The degree of shortening of the neck and mushrooming of the head determine the amount of limitation of abduction and internal rotation.

Limp, fatigue after use or long walks and recurrence of acute joint symptoms following hard labor is usually complained of when these later changes have occurred.

A case of Perthes' disease is presented as observed in:

J. V. H.—Age 22, male, single, white, born in U. S., chauffeur. Family History—Orphan, unknown. Past history—Right leg always longer than left. Denies venereal disease. Operation for right hydrocele in 1928. Cast on left lower leg for ten weeks in 1931.

Present Illness—Limped on left leg "all life" and for past three years left leg "troubled him." Following enlistment in CCC in October, 1934, two days' duty in digging ditches compelled him to "turn in" with pain and increasing stiffness in the hip joint and leg. These symptoms subsided after five days' rest in bed. Urine—SG-1034—Negative chemically and only an occasional pus cell noted microscopically. Stools—Negative for parasites and ova.

Admission diagnosis:

1. Ankylosis of left hip joint.

2. Congenital dislocation of the hip considered.

X-ray diagnosis: Legg-Perthes' Disease. "The plates show considerable tilting of the pelvis to the left. Shortening of the neck of the femur. Loss of the joint space in the acetabular cavity. Rarefaction of bone at this site. The ankylosis is seemingly complete."

The surgical treatment of a case in the advanced stage of this reported patient must take into consideration his economic status. Nature is progressing toward a cure by final complete ankylosis of this hip joint. Until this is attained recurring disability will be the rule whenever strain or work trauma is called into play and inasmuch as this man is on relief rolls after discharge from the C. C. Corps, it will only anticipate a natural cure by an operative fusion of the joint, thereby the sooner permitting him to perform work that is now not possible.

For the patient that can afford the time, expense and after followup treatment, an arthroplasty with the interposition of a flap of fascia in the joint would be the indicated treatment of choice with every hope of obtaining an excellently functioning joint.

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TREATMENT OF ECLAMPSIA

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This paper is to deal chiefly with the treatment of eclampsia. It is my purpose to offer the best treatment available in our own community with the facilities which we have at hand.

[1]"Eclampsia is a convulsive disease peculiar to the later months of pregnancy, usually characterized by hypertension, albuminuria, and edema chiefly of the extremities." It is associated with progressive symptoms of headache, vertigo, disturbances of vision, epigastric pain, tonic and clonic convulsions and sometimes coma and death. The evidence of eclampsia varies in different localities and different countries. "It is more common in cold countries than in temperate climates. It occurs once in every 68 deliveries among primiparas and once in every 4,000 multiparas. The percentage of the recurrence of eclampsia lies between 1.5% and 8%."

It is not within the realm of this paper to present the countless theories of the cause of eclampsia. Suffice it to say that while many more or less tenable theories have been advanced, still the proven cause of eclampsia remains obscure. It is fitting, however, that the prodromal symptoms of impending eclamptic convulsions be enumerated: edema, chiefly of the extremities; severe and persistent diffuse headaches; disturbances of vision such as flashes or spots before the eyes; epigastric pain and distress; muscular twitching, restlessness, nervous irritability and sleeplessness. The two outstanding findings are hypertension and albuminuria.

An eclamptic convulsion presents a terrible picture. [1]"The onset is abrupt, frequently initiated with a sharp cry. This is followed by clonic convulsive jerkings of the muscles of the face and extremities, grinding of the teeth and the appearance of froth, often bloody, on the lips. The eyes are staring and fixed with widely dilated pupils; the face is flushed and the veins distended. The convulsion lasts from 30 to 60 seconds and is usually followed by a tonic rigidity for a short period. Cyanosis is usually present; pulse is rapid and full; involuntary movement of urine and feces occur and a deep coma usually follows, lasting from a few moments to several hours. As the convulsions proceed they become more severe, often with shorter intervals between them; more marked cyanosis; rapid pulse and gradually deepening coma and death. In rare instances death may follow one or several convulsions, although the average in fatal cases may be between ten and twenty."

Prognosis: In the United States there were in 1928, 3,821 deaths from eclampsia, an incidence of 25.9% of the total deaths from puerperal causes. The maternal mortality following the treatment of eclampsia by cesarean section is 42.4% while the conservative treatment has a maternal mortality of only 2.6% to 9.3%. The highest death rate is in prepartum eclampsia, especially in primiparas. The infant mortality is higher than that of the mothers, ranging from 24% to 40%. Many fetuses die undelivered, others from prematurity, toxemia, injuries at

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birth, or possibly as the result of drugs used to control the mother's convulsions.

Treatment: The treatment of eclampsia is conservative. This statement cannot be emphasized too strongly. In eclampsia one should not lose sight of the fact that the woman who suffers from this disease is toxic. Eclampsia is a general toxemia and a very severe toxemia. To forget this fact is to invite disaster. Therefore, the general treatment of this disease resolves itself into three methods of procedure: (1) radical, meaning treatment by cesarean section, version and extraction, and accouchement force; (2) middle line, meaning treatment first to control convulsions then radical interference as soon as convulsions are controlled; (3) conservative treatment, meaning treatment first to control convulsions, induction of labor if necessary, shortening of the second stage of labor and preeminently the avoidance of any undue trauma.

Cesarean section has no place in the treatment of eclampsia and is highly unsatisfactory, carrying as it does the highest maternal mortality of any method of procedure. It is indicated in only one circumstance and that is where there is enough disproportion between the fetal head and the birth canal to render delivery normally impossible. This is the only indication for the use of cesarean section in eclampsia. I wish to mention again that this method of procedure causes a maternal mortality of 42.4%. Version and extraction is also contraindicated except in those cases in which one finds a fully dilated cervix, no disproportion and the necessity to end labor as speedily as possible. Taking these factors into consideration, version and extraction is indicated, but rarely. Accouchement force is also condemned as it causes a great deal of trauma and shock and these two conditions are the ones which are to be avoided at all costs. These radical methods of treatment have been mentioned chiefly to condemn them. In eclampsia we have not only a toxic mother to deal with but also a toxic fetus. This fact should be borne in mind and the mother's best interests always first served. The conservative treatment combined in some cases with the middle line treatment has given by far the best results in the treatment of eclampsia. The first consideration is, of course, the control of the convulsions. The patient should be removed at once to a well equipped hospital, placed in a private room, isolated so far as possible from all noise and confusion. The best place for her is in a sound-proof room that is kept darkened and is removed from all excitement and external stimuli, so far as possible. She should have competent nurses and everyone, except the physician and nurse on the case, excluded from the room. There are several methods for the control of the convulsions. I mention only two in this paper because these have proved of the most value: the Stroganoff method and the relatively new method of treatment with the use of sodium amytal.

The Stroganoff method is based primarily on relief of convulsions by sedative measures. For this purpose he uses morphine and chloral hydrate. The patient is given morphine ¼ gr. hypodermically; one hour later 20 to 40 grs. of chloral by rectum; two hours later the same dose of morphine is repeated. This is followed at intervals of 4-6 and 7 hours by administration of chloral by rectum in doses of 15 to 30 grs. A small cleansing enema is first given, then the chloral is dissolved in 150 cc. warm water and injected slowly into the rectum. Under this regime he found that some patients had no labor; in others, convulsions ceased from hours to days only to recur; still others went into labor spontaneously, during the convulsions or following control of them. For some patients whose convulsions were not satisfactorily controlled he advised induction of labor. After the cessation of convulsions additional measures for reducing hypertension and other manifestations of toxemia have been advised. Intravenous injections or infusions of 5, 10, 20 or 50% glucose solution are very valuable because of their diuretic action as well as the theory that they save the liver and supply glucose as food to the patient. It is advisable to give insulin with the glucose solution at the rate of 1 unit of insulin to every 3 grams of glucose. It is not advisable to give more than 10 to 15 units of insulin unless there is already present a hyperglycemia. The use of solution of magnesium sulphate is valuable also in the control of eclamptic convulsions partly because of its sedative action and partly because it reduces edema of the brain and other tissues and produces diuresis. The use of magnesium sulphate intravenously is dangerous and it is best given intramuscularly in doses of 2 cc. of a 25% solution. This may be repeated following each convulsion, unless the patient is in coma. When the diastolic blood pressure is more than 120 mm. and convulsions impend or when there

is cyanosis, 300 to 500 cc. of blood may be withdrawn by venesection. Examination of the ocular fundi is important and should be done as well as a chemical analysis of the blood, particularly blood sugar, carbon dioxide combining power and total nonprotein nitrogen.

The use of sodium amytal in eclampsia has proved of great value and is probably the drug best adapted to the control of the convulsions. The usual dose required is 7½ grs. of sodium amytal in 10 cc. of water. This is given intravenously at the rate of 1 cc. per minute. Precaution should be taken that the drug is not administered any more rapidly than this. If necessary, morphine may be given in conjunction with the sodium amytal in ¼ gr. doses by hypodermic injection. The amytal may be repeated every 4 hours, 3 grs. being given by rectum to control convulsive seizures. If amytal has to be given freely, atropine should be given along with the amytal to guard against and overcome the edema of the lungs which will develop. When the amytal, initial dose being given intravenously, is under way the respiratory rate and falling blood pressure, the result of the drug, should be closely watched. If necessary a calcium chloride ampule should be given to guard against respiratory failure. After the convulsions have been controlled a period of 20 to 30 hours of watchful waiting is indicated. At the end of this time if labor has not started spontaneously, then labor should be induced at once. The method of choice depends on the surroundings and the facilities. In an appreciable number of cases medical induction is of value as it stimulates an already irritable uterus to contractions and labor ensues. If necessary the castor oil may be given by duodenal tube. The dose is two ounces, an should be followed by three doses of quinine sulphate 5 grs. to the dose at hourly intervals. If this simplest of methods is not successful then several methods are applicable. In a multipara frequently the rupture of the membranes is sufficient to induce labor. The use of the Voorhees bag is a good method, especially if the cervix is sufficiently dilated already to permit its easy insertion. One may also use catheters if the bag is not admissible. Two large catheters are inserted into the uterus between the membrane and the uterine wall. Then a vaginal pack is placed to hold the catheters in place. These methods should be instituted under a light general anesthesia, preferably ethylene and oxygen. The paramount principle in all of these methods is to avoid trauma so far as is possible.

Conclusions

(1) Eclampsia is best treated by the conservative methods outlined.

(2) Cesarean section has no place in the treatment of eclampsia except in those few cases in which it would be impossible for the woman to deliver normally even though eclampsia were not present.

(3) The proper and immediate control of eclamptic convulsions is the first consideration.

(4) After this has been done their immediate and rapid delivery by use of the method which will produce the least trauma and the most rapid result.

(5) For the first 48 hours post-partum the eclamptic woman should receive sedation to prevent the recurrence of convulsions. 2 cc. of a 20% solution of magnesium sulphate with ¼ gr. morphine should be given intramuscularly every 8 to 10 hours.

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SOME SURGICAL ERRORS*

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It has been said that undertakers cover up the mistakes of doctors. This statement might be amusing if it were not only too often a tragic truth.

There has been much written about the treatment of pimples and boils of the upper lip, in the nasal orifice, and the side of the nose and cheek. Once upon a time, it was the rule to lance all of these offending factors and hope the grim reaper would stay away. When one of these boils appears, nature throws a protecting wall beyond the inflammatory area, and in that way, tries to protect the unfortunate, who is subject to such an invasion.

The treatment should be vaccine, heat, and radiation, either the ultraviolet ray or the x-ray, and there is no valid excuse for the promiscuous lancing of these inflammatory processes in the

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region of the upper lip and environs of the nose, since the drainage of that part of the face is through two rather large veins, one on either side of the nose, that go directly to the sigmoid sinus at the base of the brain. Since the sigmoid sinus is a large, expanded, vascular portion of the venous circulation, literally a lake in the base of the brain, infection carried from these pimples and boils into this pool of blood, offers a fertile field of infection in this slow flowing area and, when once infection is implanted there, the patient is doomed.

I saw a young man who was being treated by a specialist, one of the six weeks' variety who had made a failure at general practice of medicine and had gone away to attend a clinic for a period of six weeks. This patient had developed a little abscess inside of the ala of the nose. The specialist split it open. The next day it was more troublesome and he cut it again. The third day he took the patient to the hospital. He cut it again. On the morning of the fourth day, I saw this patient and the doctor told me, before I saw him, that the patient was perfectly all right, and it was just an anxious and foolish wife who was worrying. She was six months pregnant, and had a reason for worrying, because the man had developed a sigmoid sinus infection, with a marked meningeal involvement, which ended his career in the next twenty-four hours.

Another young man, treated by a country practitioner for a boil on the upper lip, had had his lip lanced three times in the course of two days. I saw him on the night of the fourth day. He died while I was making a hasty examination.

I have not seen the occasion for lancing one of these conditions in many years, and, while the patient might suffer a little more pain, either waiting for eruption or absorption, that way is certainly better than a funeral.

Another young man pulled a hair out of a little pimple, just within the nasal fossae. This became very aggravated. He went to a physician who promptly cut it open. Death followed in three and a half days. Whether the doctor in the case was a regular attendant of the Medical Society meetings, I am not able to say, but a member of this Medical Society had given an excellent and most exhaustive paper upon the subject of sigmoid sinus infections, their causes, and the preventive treatment, which should have warned every doctor of that society against the use of a lance in those cases.

If you have no other agency of treating these cases, just use hot packs until the pimples or boils erupt themselves and you will always be on the safe side. In these cases, if the scalpel had been forgotten, and heat applied, there probably would have been no deaths.

In advanced appendicitis with gangrenous formation, frequently, in the first eight to twelve hours, there is no abnormal temperature, and in one case the patient showed no rise in temperature in thirty hours. Nausea and vomiting were entirely absent. Little or no pain was elicited upon pressure. The patient became appendix-conscious about eleven o'clock Saturday morning. Blood count, at one o'clock, showed ten thousand, eight hundred, with seventy-one per cent poly cells. The patient was ordered to take an enema, eat very little, and report if further symptoms developed. Sunday afternoon, about twenty-seven hours after the initial onset, the patient called me, and said that if I thought he had appendicitis, he would like to have me take it out some time. I asked if he was in pain, and he said: "No."

I asked him if he felt bad and he said: "No, except when I get up, I feel a little heavy in my side."

I went around to see him. Temperature was ninety-eight and four-tenths. Pulse seventy-six. Abdomen was flat, soft, and on deep pressure, on the right side, rather high up, he elicited a little pain. There was no evidence of nausea, whatever, from the beginning of this case. I told him to go down to the hospital in the evening and I would take his appendix out the next morning.

I saw him again at eight o'clock Sunday night in the hospital. At that time, he had a temperature of ninety-nine; was perfectly comfortable, and was chatting with his sweetheart. Just before the operation, on Monday morning, at eight o'clock, he had a temperature of one hundred and one. There was still no pain, no nausea, and no distention of the abdomen.

I opened the abdomen through a right rectus incision, and to my surprise, uncovered an unusually long, gangrenous appendix, retrocecal, and running well up under the liver margin. It was so friable, that I had to handle it, wrapped in gauze, with the utmost care, in dissecting it free. This was a very difficult job, but was suc-

cessfully accomplished, and convalescence was uneventful.

This was one of the most symptomless, inflammatory and gangrenous appendices that I have ever seen, and the period of temperature absence was longer than any I can find on record.

John B. Murphy always stressed a rise in temperature while Wilkie pointed out that frequently acute appendicitis was temperature free for the first eight hours. This case was temperature free for more than twenty-four hours.

Another abdominal condition, coming within the field of the gynecologist, comparatively rare in the symptom complex which it presents, is that of a leaking pus tube which presents all the evidence of an upper abdominal condition, all the way from a picture of a perforated stomach or duodenal ulcer to an acute hydrops gall bladder, with profound prostration, with a sudden rapid rise in white blood cells. This count will be found in the thirty to forty thousands, and will jump to fifty, and even to sixty thousand in a period of three to four hours. There is also a rapid pulse with profound shock. If a diagnoses of "acute abdomen" is made and these patients operated upon while in that stage of shock, most of them will die and very promptly, because usually an upper abdominal opening is made when the trouble is down stairs.

One of the most beautiful girls in the State of Florida was operated upon by mistake and the undertaker "covered it up."

I just had such a case to deal with within the last two weeks, and it was only the extreme prostration of that patient, which prevented me from making a blunder which I had made once before, a number of years ago, and which I have seen made several times by very competent men. It always behooves one to look out for a leaking pus tube and when in doubt, a smear from the cervix might give you the desired information.

Too often one prepares to remove an appendix, reaches down and gets ahold of the appendix, either ties and cuts it off and lets the stump drop back, or pursestrings and inverts the stump without ever examining the cecum for the presence of adenomatous growths, polyps and enteroliths.

I had a patient who had the symptoms of chronic appendicitis for two years, with acute exacerbations and remissions coming every two or three months. This patient consistently refused operation until one day in February, while teaching school, immediately after the noon recess, she said she felt a very peculiar thing taking place inside of her and described it as a landslide. This was followed by some degree of pain. She finished the two hours of school and came to the office. She had a very fat abdomen and little could be made out by examination; no temperature, and a blood count of eleven thousand, eight hundred, with poly cells seventy-eight per cent. I told her that I still felt it was her appendix giving her difficulty and again advised her to go in to the hospital for an operation. She refused, but on going home, became very nauseated, and when she arrived home, began vomiting. She called me and told me about it and I again told her to go to the hospital, which, to my surprise, she promptly did.

Under spinal anesthesia, I made a long, right rectus incision, and ran into a conglomerate mass of intussuscepted bowel, with the head of it directly in the middle of the transverse colon. I tried, in vain, to reduce this intussusception but very soon became convinced that this was impossible, and began resection of the gut. The meso colon was very fat and the crowding from the intussusception made it very thick, so that it was quite difficult to tie off; however, I removed the whole mass and did an anastomosis of the ileum to the transverse colon. On opening this specimen, I found a large papilloma the size of a duck egg, attached to the inside of the head of the cecum, between the opening of the ileum and the appendix. This was attached by a strong pedicle. Pathological examination of this tumor showed an adenocarcinoma, beginning on its distal end. This patient made an uneventful recovery. It is barely possible that this appendix could have been taken out, before this intussusception took place, without recognizing the presence of that tumor. Many appendices are taken out, where advanced disease of the cecum fails to be recognized, particularly, the presence of polyps on the apices of which adenocarcinoma is prone to develop.

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ANNUAL MEETING OF THE SOUTHERN MEDICAL ASSOCIATION

The Southern Medical Association is the one medium of the South through which any southern doctor may express his ideas on medical subjects. Membership in this body is open to every qualified physician in the seventeen Southern states which compose the geographical area of the organization. Every member has a right to the floor in the scientific meetings, is privileged to show scientific exhibits, and to present to the Association clinical and research achievements in medicine. Annually there is awarded by the council a medal for outstanding research work.

Since by charter the activities of the Southern Medical Association are limited to the purely professional side of medicine, and the Association is prohibited from considering economic or political questions, as is done by the American Medical Association and the various state associations, it follows that the Southern is actually the largest medical body in America devoted solely to questions of scientific medicine.

Naturally with one objective which covers such a broad field many divisions are necessary in order to include the various lines of medical endeavor of today. So there are twenty-six sections that have scientific programs and exhibits at the annual meeting. Besides these special programs, there are general clinical meetings and this year at St. Louis there will be an added day of clinics given by the members of the professon of that city. It would be difficult for a doctor in four days to have more medical instruction than he will get at an annual meeting of the Southern Medical.

November 19th to 22nd, St. Louis will be the host to the organization. With its two outstanding medical schools and excellent local profession, the city well deserves its reputation as a medical center. During several generations she has held an important position in the business and cultural life of the Mississippi Valley. She is a city with many varied and fascinating interests.

The local profession and the woman's auxiliary are planning sufficient entertainment to leave no idle hours to any doctor and his wife between the periods of the scientific program. They most cordially urge us to be their guests.

The profession in Florida has a very special reason for joining in the activities of the organization and attending the St. Louis meeting; for this year ours is the honor of having the presidency filled by a Floridian, Dr. H. Marshall Taylor. A committee is arranging with the Atlantic Coast Line Railway for a special train which will be designated "The President's Special." It will leave Florida in time to arrive at St. Louis on Tuesday, November 19th, sufficiently early for us to attend the opening meeting Tuesday morning. It is hoped that Florida registers a delegation second in number only to that of Missouri.

WARNING! WATCH FOR SWINDLER

A letter was mailed by the Association's office on September 20 to presidents and secretaries of all component county medical societies, giving information regarding a reported swindler, C. J. Anderson, who has been working among doctors, as well as others. Anderson, it seems, represents himself as a salesman for the Three Pay Sales Corporation. A letter from that firm states that Anderson was formerly employed by them but had been discharged some time ago.

It is reported that Anderson takes subscriptions for magazines on a club plan whereby premiums such as books and accident insurance are given to the subscriber in addition to the magazines; that he usually displays a list of local residents who have subscribed to the magazines through him; collects a down payment; and gives a printed, numbered receipt, but of course fails to turn the money in to the Three Pay Sales Corporation.

If apprehended, this individual should be turned over to the proper authorities.

PRESIDENT'S SPECIAL

TO

SOUTHERN MEDICAL ASSOCIATION



ST. LOUIS, MO.

For the convenience of members attending the 29th Annual Meeting of the Southern Medical Association, November 19-22, St. Louis, Missouri, arrangements have been perfected for a "PRESIDENT'S SPECIAL."

Through sleepers will be operated from Miami, Tampa, Jacksonville.

ROUND-TRIP FARES

STARTING POINT	PRICE
Deland	$41.85
Daytona Beach	41.95
Defuniak Springs	31.55
Fort Myers	46.90
Gainesville	38.25
Jacksonville	37.55
Lakeland	42.35
Miami	51.80
Monticello	33.20
Marianna	33.80
Ocala	39.55
Orlando	42.60
Pensacola	28.80
Sanford	42.50
St. Petersburg	44.00
Tampa	43.10
Winter Haven	43.35
West Palm Beach	49.10

SCHEDULE

STARTING POINT	ROUTE	TIME	DATE
Lv. St. Petersburg	A. C. L.	5:00 pm	Sunday ....November 17
Lv. Tampa	A. C. L.	6:00 pm	" " 17
Lv. Pensacola	L. & N.	9:20 pm	" " 17
Lv. Lakeland	A. C. L.	2:00 pm	Sunday ....November 17
Lv. Orlando	A. C. L.	3:23 pm	" " 17
Lv. Miami	F. E. C.	11:00 am	Sunday ....November 17
Lv. West Palm Beach	F. E. C.	12:40 pm	" " 17
Lv. Fort Pierce	F. E. C.	2:08 pm	" " 17
Lv. Daytona Beach	F. E. C.	4:52 pm	" " 17
Lv. Jacksonville	A. C. L.	8:40 pm	Sunday ....November 17
Lv. Atlanta	N. C. & St. L.	8:00 am	Monday ....November 18
Lv. Chattanooga	N. C. & St. L.	12:35 pm	" " 18
Ar. Nashville	N. C. & St. L.	4:30 pm	" " 18
Lv. Nashville	L. & N.	7:00 pm	" " 18
Ar. St. Louis	L. & N.	7:45 am	Tuesday ....November 19

TICKETS ON SALE DAILY; RETURN LIMIT 15 DAYS

Tampa sleepers and those for Georgia members will be attached to the "President's Special" at Atlanta.

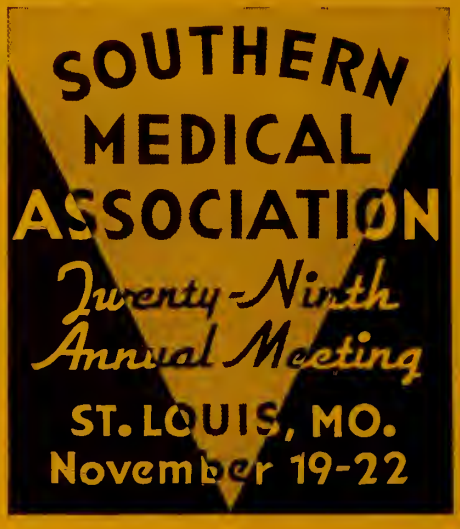
Members from the extreme western portion of the State will leave Pensacola in through sleeper at 9:20 PM., November 17, arriving Nashville 6:40 PM., November 18.

Through sleepers for members from Alabama and Tennessee will be attached to the "President's Special" at Nashville where a brief stop provides opportunity for dinner at hotel.

Through service means that doctors will be taken from starting point to St. Louis without changing cars.

RESERVATIONS: In order that ample Pullman accommodations may be provided, it is suggested that members communicate with Dr. E. T. Sellers, St. James Building, Jacksonville, advising type of space desired.

(See Reverse Side)



THE OUTSTANDING MEDICAL MEETING of the year—the Annual Meeting of the Southern Medical Association in St. Louis in mid November. In the nine general clinical sessions, the sixteen sections, the eight independent medical societies meeting conjointly, and the scientific and technical exhibits, every phase of medicine and surgery will be covered—**the last word in modern, practical, scientific medicine and surgery.** Addresses and papers by distinguished clinicians not only from the South, but from all over the United States, as well as from several foreign countries.

Regardless of what any physician may be interested in, regardless of how general or how limited be his interest, there will be at St. Louis a program to challenge that interest and make it worth while for him to attend.

EVERY PHYSICIAN IN THE SOUTH who is a member of his state and county medical societies can be and should be a member of the Southern Medical Association. The annual dues of $4.00 include the Association's own Journal each month, the Southern Medical Journal — the equal of any, better than many.

SOUTHERN MEDICAL ASSOCIATION
Empire Building
BIRMINGHAM, ALABAMA

(See Reverse Side)

PROGRAM
FLORIDA EAST COAST MEDICAL ASSOCIATION

Friday and Saturday, November 1 and 2, 1935.
Monson Hotel, St. Augustine.

Friday, November 1
10:00 a.m. to 12:00 noon.

Dry Clinic at Flagler Hospital, sponsored by the St. Johns County Medical Society.

Scientific Session
Civic Center,

2:00 p. m.

1. (Surgery) "Repair of Lacerations"—George M. Green, Daytona Beach.
   Discussion: J. Ralston Wells, Daytona Beach.
2. (Gynecology) "Endometritis"—I. M. Hay, Melbourne.
   Discussion: Walter C. Jones, Miami.
3. (Radiology) "Recent Advances in Radiation Therapy"—Gerard Raap, Miami.
   Discussion: O. O. Feaster, St. Petersburg;
   Frazier J. Peyton, Miami Beach.
4. (Medicine) "Important Consideration in Handling Diabetic Patients"—T. Z. Cason, Jacksonville.
   Discussion: Louie Limbaugh, Jacksonville;
   Meredith Mallory, Orlando.
5. (Urology) "Personal Impressions Gained from Fifteen Years' Experience in Treating Gonorrheal Infections"—Roy J. Holmes and Milton M. Coplan, Miami.
   Discussion: E. T. Sellers, Jacksonville.
6. (Urology) "Prostatic Resorption"—Maximilian Stern, Daytona Beach.
   Discussion: Robert B. McIver, Jacksonville;
   Roy J. Holmes, Miami.

7:30 p. m.

Banquet and Entertainment at Monson Hotel.

Saturday, November 2
Scientific Session
Civic Center,

9:00 a. m.

7. (Gynecology) "Sterility—Diagnosis and Treatment", (X-ray film demonstration)—Ferdinand Richards, Jacksonville.
   Discussion: Charles J. Collins, Orlando;
   Homer L. Pearson, Miami.
8. (Dermatology) "Fungus Infections of Hands and Feet"—Wiley Sams, Miami.
   Discussion: J. L. Kirby-Smith, Jacksonville;
   Alan Brown, Jacksonville.
9. (Public Health) "Communicable Disease Control with Especial Reference to Poliomyelitis"—Henry Hanson, Jacksonville.
   Discussion: N. A. Upchurch, Jacksonville.
10. (Pediatrics) "Problems of the Newborn—A Clinical Viewpoint"—Warren Quillian, Coral Gables.
    Discussion: Chas. Kennon, Miami;
    John W. Hayes, Jacksonville.
11. (Neurology) "Diagnosis of Brain Tumors"—J. G. Lyerly, Jacksonville.
    Discussion: Percy L. Dodge, Miami;
    W. H. Spiers, Orlando.
12. Address (by invitation), "The Treatment of Burns"—Daniel C. Elkin, Professor of Surgery, Emory University, Atlanta.

All papers limited to 15 minutes maximum. Discussions limited to 3 minutes individual maximum.

Business Meeting
12:00 noon.

Reports of Secretary and Committees.
Election of Officers.
Selection of Meeting Place for 1936.
Drawing of Attendance Prize. (There will be an extra charge of 50c for all those who desire to participate in the usual drawing for the attendance prize).

3:00 p. m.

Football game in Jacksonville. Georgia vs. Florida.

* * *

The registration fee of $2.50 will include banquet and entertainment. For guests and visitors, there will be a charge of $1.50 for the banquet and entertainment.

DRAMATIZED RADIO PROGRAMS FOR MEDICINE AND HEALTH!

"your health
ladies and gentlemen . . ."

This toast—through the music—each Tuesday at 5:00 p. m. Eastern Standard Time (4:00 p. m. Central Standard Time, 3:00 p. m. Mountain Time), will introduce the new radio program of the American Medical Association. It is offered over the Blue network of the National Broadcasting Company, beginning October 1, 1935. With the cooperation of the National Broadcasting Company, a new type of program, in vivid dramatic form with incidental music, is being developed, showing

MEDICAL EMERGENCIES AND HOW THEY ARE MET!

The hero of the medical emergency, the doctor who is available day and night for the protection and promotion of YOUR HEALTH, is the real sponsor of this series of practical and entertaining health broadcasts.

Each Tuesday—

". . . ladies and gentlemen,
your health"

BLUE NETWORK, N. B. C.: WJZ—WSYR—KDKA—WCKY—WENR—WIBA—KSTP—WEBC—KFYR—KWCR—WREN—KWK—KSO—WBAL—WMAL—WTAR—WPTF—WWNC—WSOC—WIS—WSM—WMC—WJDX—KVOO—WKY—WFAA—KTBS—WOAI.

(Pre-printed from HYGEIA, the Health Magazine, October, 1935)

CORRESPONDENCE

To the Editor:

DEBATE: "MEDICAL SERVICE AT PUBLIC EXPENSE" TO BE BROADCAST

I think you are aware of the fact that some thirty or more high school debating leagues are debating this year the following question:

"*Resolved:* That the several states should enact legislation providing for a system of complete medical service available to all citizens at public expense."

The medical profession throughout the entire country has been most helpful in assisting these schools and debaters in securing authoritative information.

The National Broadcasting Company is providing the facilities of its Red Network for a chain broadcast on this question on Tuesday afternoon, November 12. The following statement gives the essential facts concerning this broadcast:

SPEAKERS:

Affirmative: William Trufont Foster, Director, Pollak Foundation. Professor Bower Aly, University of Missouri, Editor of the Debate Handbook.

Negative: Dr. Morris Fishbein, Editor, Journal of the American Medical Association. Dr. R. G. Leland, Director, Bureau of Medical Economics, American Medical Association.

TIME—November 12, 2:00 to 3:00 p. m., Eastern Standard Time (1:00 to 2:00 p. m., C. S. T.; 12:00 to 1:00 M.S.T.; 11:00 to 12:00, P.S.T.)

STATIONS BROADCASTING—N. B. C. Red Network and affiliated Stations.

No doubt many of your members will be interested in hearing this debate as I anticipate there are no two speakers who can present the negative more effectively than Dr. Fishbein and Dr. Leland. Perhaps you can arrange to see that the information reaches all of your members, either through an announcement in your monthly publication or through a special bulletin or post card. We have no information as to the exact list of stations which will handle this broadcast so each person interested should get in touch with the radio stations in his area, urging those affiliated with N. B. C. to carry the broadcast for the benefit of the high school debaters, the medical profession and others interested in this discussion.

If we get definite information later, I shall endeavor to send you a complete list of the stations included in the network on this occasion.

Sincerely yours,

HAROLD G. INGHAM,
Chairman, N.U.E.A. Committe on Debate Materials and Interstate Cooperation.

* * *

To the Editor:

The Economics Committee of the Florida Medical Association has had a number of meetings with representatives of the Social Welfare Division of Florida. We have agreed upon the plan for securing funds from the government to finance medical, dental, and pharmaceutical care of the indigent sick. The following letter is a brief outline of what the Committee is advising the United States Government to contribute through the state welfare fund to make this possible.

(Signed) J. S. TURBERVILLE, M.D.,
Chairman, Committee on Medical Economics.

September 26, 1935.

Honorable Harry L. Hopkins, Administrator
FERA and WPA
Walker-Johnson Building
1734 New York Avenue, N.W.
Washington, D. C.

Dear Mr. Hopkins:

The undersigned, who compose the membership of the Florida Advisory Council for Medical Relief, which Council represents the Florida Medical Association, Florida Dental Association, Florida Pharmaceutical Association, together with a representative from each the Florida State Board of Health and Florida Board of Social Welfare, desires to make a formal request for funds to provide medical and dental services in the office and the home, and to provide drugs and prosthetic devices to persons in the State who, by reason of lack of income, or because of inadequate income, are unable to provide such services for themselves.

The Council is of the opinion that an allotment of funds is necessary, and reasonable, in order that these needed services may be rendered to citizens of Florida. A large number of persons, estimated at more than 300,000, are unable to meet such obligations. It is also the opinion of the Council that, while the professions concerned have in years gone by met these responsibilities alone and unselfishly from their own resources,

except during a period when the Florida Emergency Relief Administration shared this responsibility with the professions concerned, rendering services of this type should not be borne alone by the doctors, dentists and druggists, but that such is a joint obligation between the professions and society.

It is the opinion of the Council that inasmuch as the State, Counties and Municipalities of Florida are meeting by the expenditure of many thousands of dollars for clinical, out-patient and hospital care to these needy persons, that in order that office and home visitations together with drugs, etc., referred to above may be had, there should be a grant by the Federal Government specifically allotted for this purpose to Florida. The amount of the grant for this purpose should, in the opinion of the Council, be based on the population of the State not to exceed $1.50 per capita per annum, and the distribution of funds should be made on the basis of population by Counties.

In rendering services of this kind, representatives of the medical, dental and pharmaceutical professions realize the value of assistance that may be given this program by the Florida State Board of Social Welfare, and are appreciative of the cooperation had from the FERA under its medical program and contemplate working with this Board and its agencies throughout the State to determine who should be eligible for these services.

The basis for a tentative agreement between the professions concerned as well as the Florida State Board of Social Welfare is attached. Details of administering the program, fees to be paid, the extent to which any of the members of the professional groups may participate in these funds in a given time may be worked out subsequently.

The Council requests the Federal Government through your office, or such other office or offices as may have jurisdiction in these matters, to make a grant to the State of Florida through the Board of Social Welfare of the State of Florida of $1.50 per capita, to be expended over the twelve months period beginning October 1st, 1935, and ending September 30, 1936, based on the State census of 1935: 1,606,842 or $2,410,263.00.

Respectfully signed,

FLORIDA ADVISORY COUNCIL FOR MEDICAL RELIEF.

(Signed) J. S. Turberville, M.D., Chairman, Florida Medical Association;
(Signed) R. P. Taylor, D.D.S., Florida Dental Association;
(Signed) J. K. Attwood, Florida Pharmaceutical Association;
(Signed) Henry Hanson, M.D., State Health Officer;
(Signed) Conrad Van Hyning, Commissioner of Social Welfare.

STATE NEWS ITEMS

Dr. L. H. O'Quinn of Hialeah was elected mayor of that city on September 11.

* * *

Dr. Julius Alexander of Miami was injured in the recent hurricane when the government hospital at Snake Creek collapsed. Dr. D. C. Main, who was in charge of the hospital, was killed.

* * *

Dr. J. Maxey Dell of Gainesville was chosen as a city commissioner for a term of two years in the annual municipal election held on September 10.

* * *

Dr. Julius C. Davis and family of Quincy have returned from a two weeks' vacation spent in Hendersonville and Waynesville, N. C.

* * *

Dr. M. A. Lischkoff of Pensacola attended the Cincinnati meeting of the American Academy of Ophthalmology and Otolaryngology. From there he went to New York to attend clinics and for some special postgraduate instruction.

* * *

Dr. and Mrs. Joseph H. Lucinian of Miami announce the birth of their daughter, Juanita Nevart, September 9 at the Victoria Hospital.

* * *

Dr. B. A. Burks of Winter Park spent the first two weeks of September in New York where he attended clinics.

* * *

Dr. Samuel Aronovitz of Miami has returned from a six weeks' stay in New York. He did work at the Mount Sinai Hospital and Columbia University. He spent some time in the Catskill Mountains and at Saratoga Springs.

Every member should turn to page 174 and read, under "Correspondence," the letter to the Editor from the Chairman of the Committee on Medical Economics, which relates to medical relief in Florida.

* * *

Dr. A. L. Rowe of Lake Worth visited clinics in New York City and Washington, D. C., during the month of August.

* * *

Dr. and Mrs. W. Y. Sayad of West Palm Beach announce the birth of a son on September 17.

* * *

Dr. Edwin T. Preston of Miami Beach has returned from Boston where he spent some time doing postgraduate work in cardiology.

* * *

Dr. Hubbard Gates of Bradenton has returned from a two months' vacation trip during which he traveled 10,000 miles. He visited Virginia and North Carolina. He then went westward, to Denver, Colo., Salt Lake City, the National Parks, Seattle, Washington, Oregon, and down through California to San Diego, returning by way of New Orleans.

* * *

Dr. Lawrence A. Klein announces the opening of offices in the Greenleaf Building, Jacksonville. Dr. Klein completed training with the Medical Reserve Corps in July.

* * *

Dr. E. B. Hardee has returned to his office in Vero Beach after an absence of two months spent in the White Mountains of New Hampshire.

* * *

Dr. and Mrs. Cayetano Panettiere of Miami Beach announce the birth of a son, Charles Vincent, on August 23.

* * *

Dr. and Mrs. Wiley M. Sams of Miami announce the birth of a son, John Hastings, on September 7.

* * *

Dr. M. Jay Flipse has returned from an extensive tour through the Rockies. On his return trip he attended the National Tuberculosis Association meeting in Houston, Texas.

* * *

Dr. E. Sterling Nichol of Miami has returned from a vacation spent at Bar Harbor, Me. He was called to his home at Columbus, Ohio, during his vacation on account of the death of his father.

The trustees of the Lilly Heard Anderson Lectureship in Pediatrics announce that Dr. Thomas M. Rivers will deliver the annual lecture at the Academy of Medicine in Atlanta, at 8 o'clock on the evening of Thursday, November 14. Dr. Rivers' subject will be "Virus Disease of the Central Nervous System." Dr. Rivers is in charge of this field of research at the Hospital of the Rockefeller Institute of Medical Research in New York City.

* * *

Dr. Rufus Pearson has returned to Miami from a trip through the West, including a tour through Yellowstone National Park.

* * *

Dr. D. Ward White of Miami Beach has returned from a trip to Canada and New York.

* * *

Dr. Gerard Raap of Miami has returned from a vacation spent with his family in Michigan.

* * *

Dr. W. Terrell Simpson of Winter Haven has returned from a two weeks' sojourn in New York during which time he completed a course in radium therapy and negotiated for the purchase of 50 mgs. of radium.

* * *

Dr. Maximilian Stern announces his return to Daytona Beach and the resumption of practice which is limited to urology.

* * *

An examination for entrance into the Reserve Corps of the United States Public Health Service in the grade of Assistant Surgeon is hereby announced to be held November 18, 1935. Applicants must not have passed their thirtieth birthday. They must be graduates of a reputable medical college and have completed at least one year of internship since graduation, or its equivalent. Successful candidates will be ordered to active duty in the Reserve Corps, in which it is expected that vacancies will occur soon after January 1, 1936, and will be eligible for examination for entrance into the regular commissioned corps when such examinations are held, provided they have not passed their thirty-second birthday.

The compensation of officers in the grade of Assistant Surgeon in the Reserve Corps is the same as that for officers in the Regular Corps; namely, with dependents, $3,158 per annum; without dependents, $2,699 per annum.

Boards will be appointed in various cities

throughout the United States so as to avoid as much travel as possible, which, if necessary, must be made at the candidate's own expense.

Persons desiring permission to take this examination should make request to the Surgeon General, U. S. Public Health Service, Washington, D. C., for the necessary blanks and other information.

EDMUND WALTER WARREN

Dr. Edmund Walter Warren, pioneer physician and surgeon of Palatka, died in St. Augustine on September 24, at the age of 61. He had been in poor health since he was injured in an automobile accident near Carraway about three years ago.

Doctor Warren was born in Blackshear, Georgia, and received his professional education in the medical department of the University of Georgia, graduating in the class of 1902. He came to Florida and began his career as a physician at Brooker, in Bradford County, and a few months later removed to Providence. He served from 1902 until 1904 as Assistant State Health Officer. In 1904 Doctor Warren began practice in Crescent City and the following year moved to Palatka, where he practiced continuously until the time of his fatal illness.

For a score of years, Doctor Warren was secretary-treasurer of the Florida Railway Surgeons' Association and was local physician for the East Coast Railway, the Atlantic Coast Line and the Georgia Southern Railway. He served as President of the Florida Medical Association from 1916 to 1917 and was for many years prior to his death secretary of the Putnam County Medical Society. Doctor Warren was a former mayor of Palatka and a past master of Palatka Lodge F. and A. M. and a member for more than 25 years of St. Johns Lodge, Knights of Pythias. He was a past president and charter member of the local Rotary Club.

Predeceased by his wife two years ago, he is survived by three sons, Representative Walter Warren and Brandon Warren of Palatka and Lamar Warren of St. Augustine.

Baynard H. Kendrick, author of "Murder on Lake Louisa," which book was dedicated to Dr. Warren in 1934, has written a fitting tribute to his doctor friend. In part, it reads as follows:

"Somewhere in Palatka today, is a set of dusty account books, unopened and untended these many years. They bear mute testimony to a lifetime of service rendered to your community. I know, for I audited them many times in the past. I have seen the pages marked in red: 'Charge Off to Profit and Loss—these people are poor.' These uncollected accounts represent a fortune. * * * In money, he was not a rich man when he died. In knowledge of work well done; in affection and esteem of those who knew him; in service to those who needed him; he died a multi-millionaire. God grant we may all die as rich as he. May all of us be able, truthfully to say: 'I answered every call for help and gave the best there was in me.' May all of us carry his passport to happiness in the final accounting: 'Charge Off to Profit and Loss—these people are poor.' "

WILLIAM CARTER PERSON

Dr. William Carter Person, son of Weldon Edwards Person and Mary Ann Jeffreys Person, was born at Louisburg, N. C., October 6, 1845.

Many physicians were among his ancestors, including that well-known and beloved name in medicine, Dr. Benjamin Rush, of Philadelphia.

He was a precocious child and learned to read at the early age of five so that he was very well able to read a copy of Robinson Crusoe, presented to him by his uncle, Dr. Charles Jeffreys, at the age of six. It is said that he read Latin at ten years of age and later Greek fluently.

In 1862, when ready to enter the Sophomore Class at the University of North Carolina, he joined his father at Coffieville, Miss., and at the age of sixteen went into the Confederate Army. He was in Troop K of the Third Mississippi Cavalry serving under General Joe Wheeler and later General Bedford Forrest.

On May 29, 1865, he was paroled at Gainesville, Ala., and, like all Confederate soldiers, was ragged, being without shirt or shoes. Still in his teens, he made his way back to Mississippi and began the rehabilitation, feeding and nursing sick negroes who had been freed.

He farmed and farmed well, so well, in fact, that he put up a bale of cotton that won a prize at the Paris Exposition. In addition to this he taught school and finally obtained enough funds to study medicine at the Missouri Medical College, now Washington University, St. Louis, Mo., from which institution he graduated in 1873.

He returned to Mississippi and entered the

practice of medicine in Yolobuska County, which he followed until his removal to Orlando in July, 1890.

On March 8, 1876, he married Mary Agnes Sanford of Ripley, Tennessee. Of this union a son, Sanford, died in childhood. The death of Sanford was never forgotten and made him particularly kind to little children.

He is survived by four children: Dr. Weldon E. Person, of Atlanta, Ga., Miss Mary Agnes Person, Mrs. Willie P. Tilden and Mrs. Jean Person Floyd of Orlando, and by five grandchildren.

Also surviving him is an elder sister, Mrs. Elizabeth Cooke, the widow of the late Judge Charles M. Cooke of North Carolina, now residing at Florence, S. C., and by numerous relatives throughout the South.

He practiced medicine over fifty-three years actively and was keenly interested in his profession until the last. A great and good man, he followed the Golden Rule in his contact with his fellow men and patterned himself after The Great Physician in professional life.

He belonged to the school of physicians whose working hours sometimes never stopped. Ministering to the sick in town and out of town with the inconvenience of inadequate transportation, he was seemingly tireless.

He served many families for years and never put their names in his books and still in spite of decreased collections, due to such a practice, he refused a summer in Europe as a private physician once because he felt his patients needed him most.

Whereas, the Orange County Medical Society, highly appreciating the mental attainments and the wise counsel of this aged and lovable physician, who was keenly alert to every advance in modern medicine, feel they have lost a kindly friend and a wise counselor from among their associates;

Now, THEREFORE, it is proposed that this memoriam be spread upon the minutes of the Orange County Medical Society, a copy be given to the local newspapers, and a copy sent to the Journal of the Florida Medical Association, also to the family of the deceased.

SPENCER A. FOLSOM, M.D., Chairman.
CALVIN D. CHRIST, M.D.
JOHN S. MCEWAN, M.D.
FRANK D. GRAY, M.D.

Dr. Hugh West of DeLand left recently for the convention of the American College of Surgeons in San Francisco. Doctor West will receive his Fellowship at this meeting. En route, he visited the Mayo Clinic for a few days.

* * *

Dr. and Mrs. S. D. W. Light of Miami are vacationing in Hendersonville, N. C.

* * *

The next annual meeting of the Association is scheduled to be held aboard the luxuriously appointed passenger liner, "Florida." Turn to the inside back cover of this Journal for additional information.

The Committee on Arrangements has had published in a number of past issues of the Journal, information concerning the plans for this annual meeting and three-day cruise of tropical waters. If you have not seen the displays and write-ups in recent Journals, please do not fail to look up this material.

FOR SALE—Entire professional equipment of the late Dr. E. W. Warren of Palatka, Florida. Army type operating table, large assortment of instruments, library, diathermy apparatus, blood pressure outfits, etc. Equipment may be purchased intact, or separately. Brandon Warren, Palatka, Florida.

WANTED — Location, assistantship or partnership. Married; 45 years old. Have Florida license. General medicine; have had special training in obstetrics and gynecology at N. Y. Post-Graduate Medical School and Hospital, N. Y. Lying-In Hospital. Will invest some money. Write No. 5099, care Journal, Box 1018, Jacksonville, Fla.

FOR SALE—Deceased physicians' library and electro-cautery outfit. Address inquiries to P. O. Box 414, Lakeland, Florida.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

By invitation of the Staff of the St. Francis Hospital, the regular meeting of the Dade County Medical Society was held at that hospital September 6th.

The Society went on record as volunteering its services, gratuitously, as a body and as individual physicians to victims of the past hurricane and in similar future emergencies and as being opposed to payment of any financial remuneration for professional care of veteran or of civilian victims of the hurricane. Certain young doctors who were employed by the FERA to care for veterans



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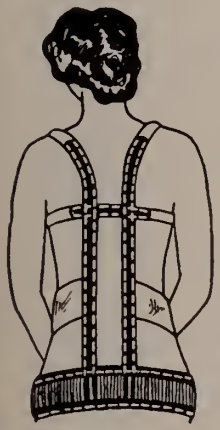
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who should be hospitalized in Miami on account of illness or injury which could not be cared for at the keys camps were excepted by this action of the Society.

On the evening of Friday, October 4, the members of the Dade County Medical Society enjoyed a dinner and dance at the Royal Palm Club.

DUVAL COUNTY MEDICAL SOCIETY

The Duval County Medical Society held its regular meeting at the Mayflower Hotel, October 1 at 8:15 p. m. The following scientific program was presented:

"Surgery of the Kidney"—Robert B. McIver.

"Congenital Hypertrophic Pyloric Stenosis"—L. W. Holloway. Motion pictures were used to illustrate both of these papers.

PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society is to be congratulated on the appearance of the first number of "The Polyscope", official publication of the Society. Dr. Feaster, the secretary, writes:

"The 'Polyscope' makes its bow! Should the membership consider it desirable, it will appear at intervals during the year. The most concrete way of expressing this desire is by contributing to its contents. Such ventures usually mean a great deal of work for a very few men who may finally be discouraged by lack of support and cease their efforts when it becomes obvious that they are not appreciated. The older members will probably remember 'The Bougie—the official dilator of the PCMS' which was a six to fourteen page mimeographed monthly bulletin that struggled on for two years, more than a decade ago. While some of the members expressed approval, they didn't say it with copy. Its death ensued. The 'Polyscope' is the brain child of our most efficient and indefatigable treasurer (W. C. McConnell). And, as usual, he is doing practically all of the work."

The "Polyscope" is a six-page, mimeographed bulletin which contains an editorial, treasurer's report, extracts from current, medical literature, and two original articles. It is hoped that it will receive the support necessary for its continuance. A bulletin has a place in the life of every large county society. Through such an organ, doctors can present case reports and exchange information which would be of too local a color to be of state-wide interest.

WOMAN'S AUXILIARY

TO THE
FLORIDA MEDICAL ASSOCIATION, INC.
State Editor
Mrs. S. M. Copeland
1356 Willowbranch Ave.,
Jacksonville, Florida

OFFICERS

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Mrs. L. C. Ingram, Finance . . . . . *Orlando*
Mrs. S. M. Copeland, Press and Publicity . . . . *Jacksonville*

Mrs. Lee W. Roe, Southern press and publicity chairman, requests that an announcement be made of the meeting of the Southern Medical Auxiliary to be held in St. Louis, Missouri, November 20th and 21st. All women attending the Southern Medical Association meeting are invited to the Auxiliary meetings.

Each State Auxiliary is entitled to send its President, two delegates, and two alternates to form with the Executive Board, the voting body.

Members and eligible members of County Auxiliaries are very cordially invited to attend the luncheon meeting Wednesday, November 20th, at 12:30 p. m., and the Annual Meeting, November 21st, at 9:30 a. m. The business sessions are to be conducted on a schedule, allowing time for social arrangements. For the development of the Auxiliary, it is important for members and eligible women to be present, because the foundation of an organization rests on its membership and future leaderships come from it. So make your plans to go to this Convention.

Doctor's Wives Entertained By Duval County Medical Society

One of the most delightful social affairs of the season was the party given August 28th at the Ponte Vedra Bath Club by the Duval County Medical Society for its members and their wives.

Swimming in the ocean was arranged for the late afternoon after which a buffet supper was served.

During the evening dancing was enjoyed to the music of a popular negro orchestra. Among those enjoying the party were: Dr. Allen Brown, Dr. C. J. Baumgartner, Dr. and Mrs. O. P. Broadbent, Dr. and Mrs. John W. Hays, Dr. and



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(*Med. Record: Dec. 5, 1934*)

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Dr. and Mrs. H. L. Brillhart, Dr. and Mrs. Victor Hughes, Dr. and Mrs. A. C. Knight, Dr. and Mrs. George Richardson, Dr. S. E. Driskell, Dr. and Mrs. B. F. Woolsey, Dr. and Mrs. Robert Baker, Dr. and Mrs. Herrman Harris, Miss Bessie Harris, Dr. and Mrs. B. A. Chapman, Dr. and Mrs. C. J. Johnson, Dr. and Mrs. Henry Hanson.

Dr. Harvey Mabry, Dr. and Mrs. F. Richards, Dr. L. A. Kline, Dr. and Mrs. Robert McIver, Dr. and Mrs. C. C. Collins, Dr. and Mrs. Theodore G. Croft, Dr. and Mrs. Clarence D. Rollins, Dr. and Mrs. Edmund H. Teeter, Dr. and Mrs. S. M. Copeland, Dr. and Mrs. W. C. Bayless, Dr. C. H. Harrell, Dr. Paul Martin, Dr. and Mrs. S. R. Norris, Dr. and Mrs. R. R. Killinger, Dr. and Mrs. Banks Goodale.

Dr. and Mrs. J. H. Owens, Dr. and Mrs. H. F. Schnauss, Dr. and Mrs. Frederick Waas, Dr. and Mrs. George Mitchell, Dr. and Mrs. Pieler, Dr. and Mrs. R. S. Wynn, Dr. and Mrs. John A. Mitchell, Dr. and Mrs. E. C. Swift, Dr. and Mrs. Murphy, Dr. and Mrs. William Kirk, Dr. and Mrs. A. B. Quasser.

* * *

The Orange County Medical Auxiliary, of which Mrs. L. C. Ingram is president, was hostess at a luncheon given at the Colonial Orange Court Hotel in Orlando at 1:00 o'clock Sunday afternoon, September 22nd, honoring the members of the Florida State Medical Advisory Board and the Florida State Medical Auxiliary Board. The members upon arrival were greeted by Dr. and Mrs. L. C. Ingram and given a most cordial welcome.

Immediately following the luncheon a joint meeting of the two boards was held in one of the large parlors of the Hotel at which time Mrs. E. W. Veal, President of the Florida State Medical Auxiliary, presided.

Plans for the coming year were then discussed by Dr. Gordon H. Ira, Chairman of the Advisory Board, Dr. Eugene G. Peek of Ocala, Dr. W. C.

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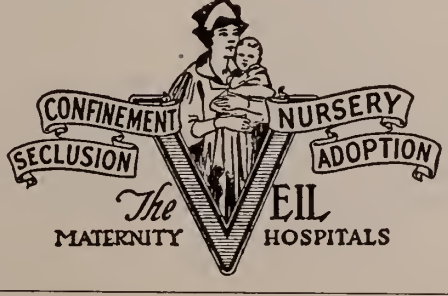
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McConnell of St. Petersburg, Mrs. W. W. Harden, President-elect of St. Petersburg, Mrs. J. Ralston Wells, Vice-President of Daytona Beach, Mrs. E. G. Peek, Historian of Ocala, Mrs. Wilburn Lassiter, Parliamentarian of Gainesville, Mrs. Gordon H. Ira, Program Committee Chairman of Jacksonville, Mrs. E. R. McMurray, Public Relations Chairman of Bartow, Mrs. L. C. Ingram, Finance Chairman of Orlando and Mrs. S. M. Copeland, Press and Publicity Chairman of Jacksonville, and a definite program was adopted. The business of health education was stressed in this year's work. It was announced that authentic inexpensive pamphlets were available concerning questions asked daily about many subjects such as child welfare, health plays, sex education, nutrition and diet, and many other vital subjects. It was voted to distribute as widely as possible the three minute talk concerning the necessity of a medical examination of household servants, stressing the point that public food handlers, beauty operators, etc., are required by law to have such examinations, yet we are careless about our household servants.

It will be suggested that each County Auxiliary in accordance with the National Program use a new study envelope this year entitled, "Healthy Hearts." A very important educational announcement was made by the Program Chairman, stating that beginning October 1st, the American Medical Association would offer through the National Broadcasting Company a new type of program, a vivid, dramatic presentation of medical emergencies and how they are met. This program to be on the air at 5:00 p. m., Eastern Standard Time, each Tuesday, beginning October 1st. From information at hand it was stated that these broadcasts would be as interesting and real, and create as much attraction as a medical emergency on a public thoroughfare.

Plans were made for the preparation of an exhibit for the first time at the next State Meeting, showing the wide scope of work carried on by the Woman's Auxiliary.

Following a discussion concerning the work of each department, the meeting closed with a general vote of thanks to Dr. and Mrs. L. C. Ingram and the Orange County Medical Auxiliary.

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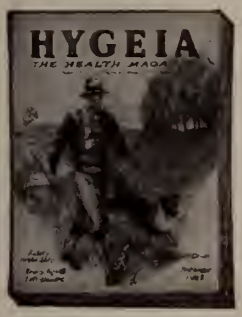


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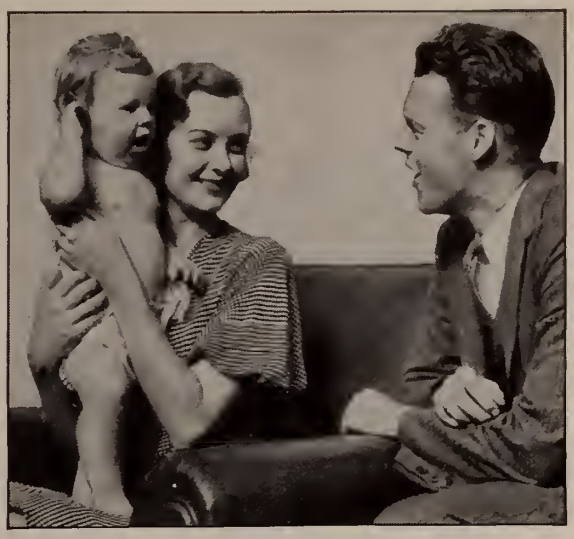
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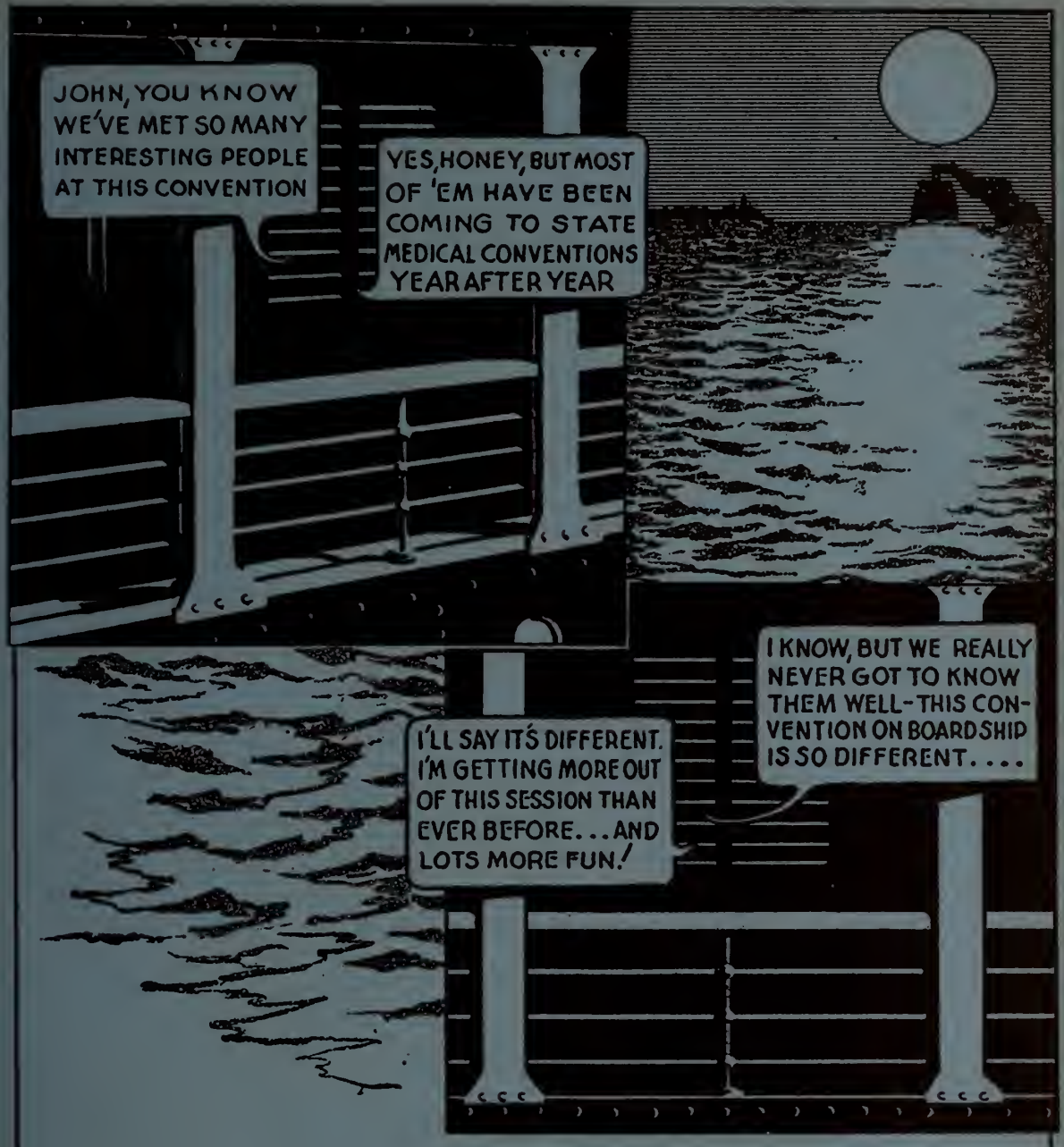
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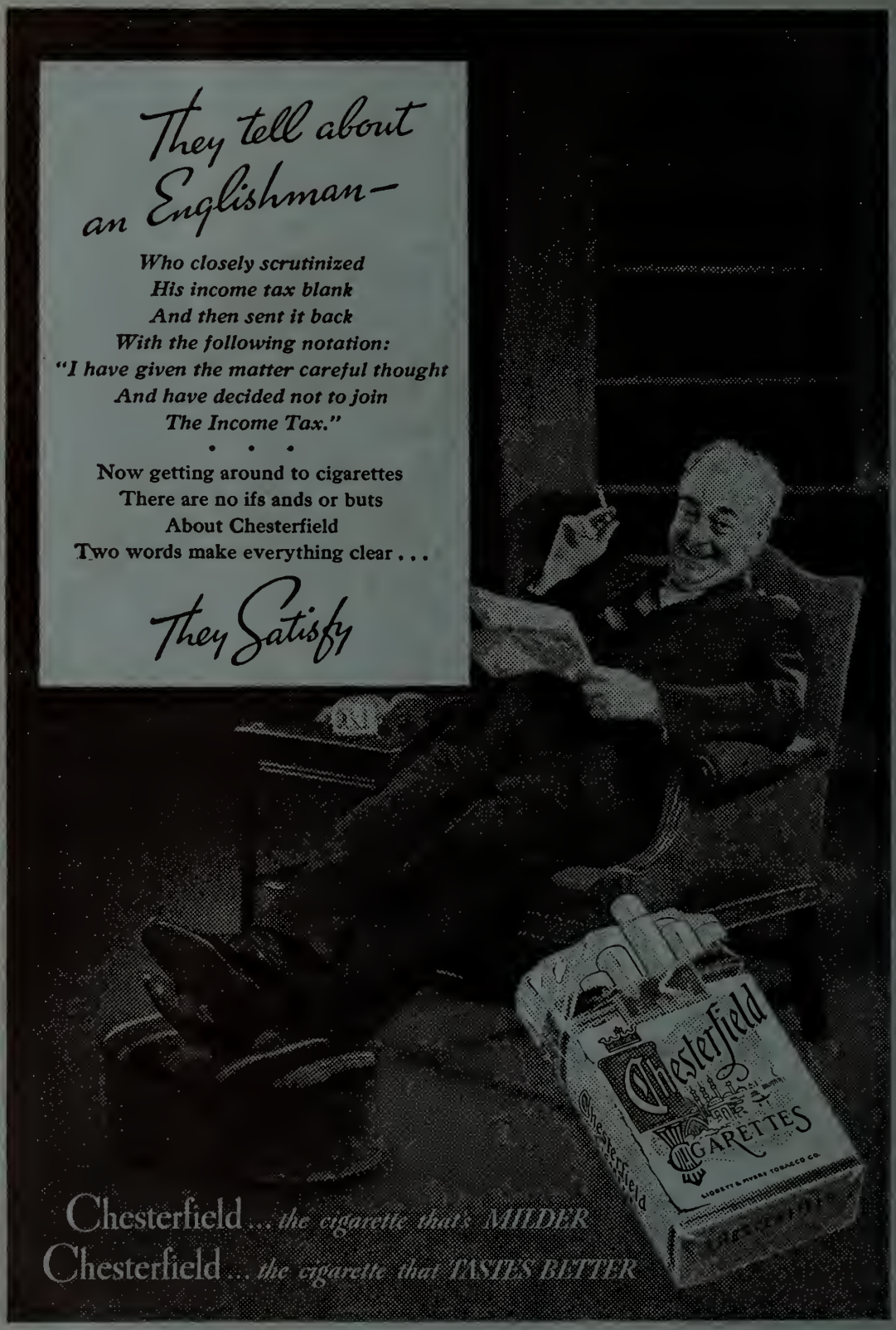
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NEXT SESSIONS

Florida Medical Association, S.S. Florida, April 27, 28, 29, 1936.
American Medical Association, Kansas City, Mo., May 11-15, 1936.
Southern Medical Association, St. Louis, November 19-22, 1935

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(1) Journal Nutrition 8, 749 (1934)
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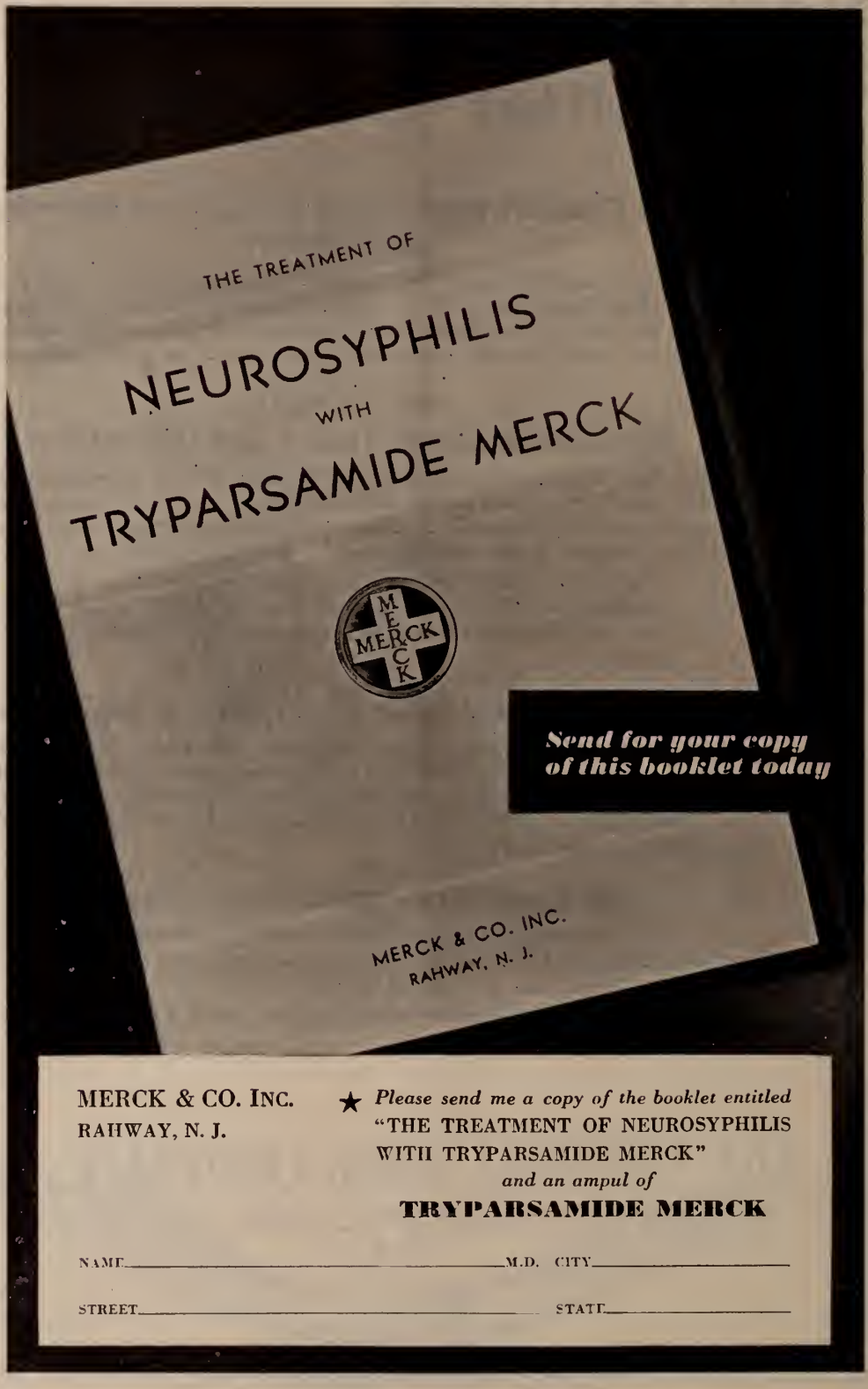
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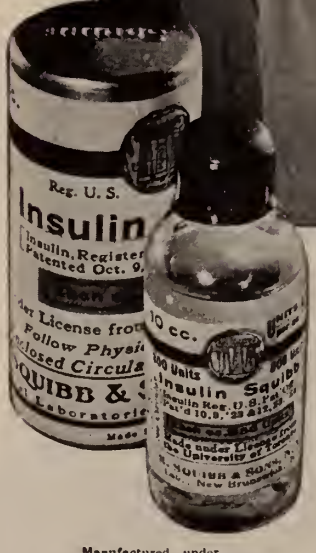
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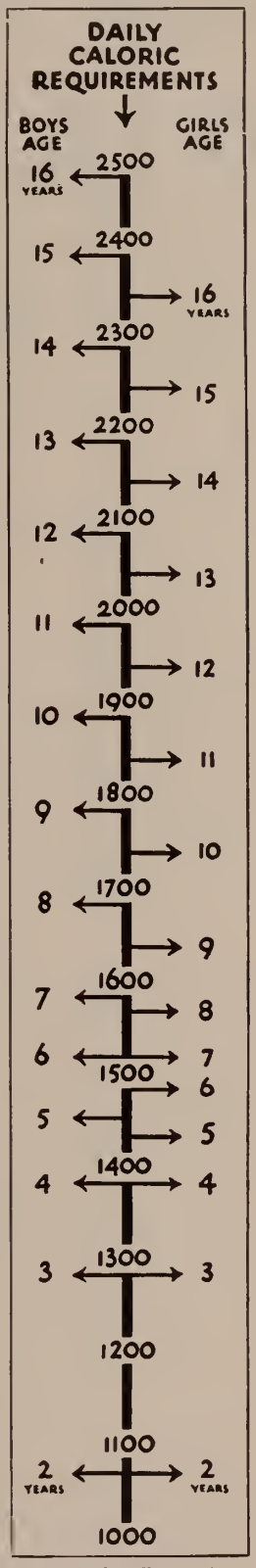
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Volume XXII | Jacksonville, Florida, November, 1935 | Number 5

THE TONSIL PROBLEM*

L. C. INGRAM, M.D.,
Orlando.

This subject, the tonsil problem, has been selected because every branch of medical practice will at some time find it necessary to consider whether a chronic infection in the tonsil is the original source of the disturbance under investigation. It is my purpose to review some of the contributions made to scientific medicine during the past twenty-five years, that have raised and in part solved some phases of the tonsil problem. The development through this period in all branches of medicine and the separation into specialties has brought to us the necessity for a closer association of effort through our membership in order to utilize to the fullest extent our present resources in diagnosis and treatment. This is usually referred to as teamwork and is the essential step if we are to utilize all this accumulated knowledge to the best interest of the patient. We will thus do better work and more certainly rid the state of any effective work of the cult. The answer to this opportunity will depend on how hard and how well we work together.

THE PROBLEM OF ANATOMY

I believe we should accept and use the more recent nomenclature of anatomical names of tonsils and lessen the possibility of confusion. The tonsils, as we understand them, consist of a connective tissue supporting framework filled with nucleated reticulo-endothelial lymphoid tissue. The palatine tonsils, formerly called the faucial tonsils, situated on either side of the pharynx, supported by the pillars, are most frequently the source of focal infection and are the tonsils usually removed in a tonsillectomy. The pharyngeal tonsil, usually called adenoid, situated in the upper part of the naso-pharynx is only of particular interest in children. It is seldom the seat of focal infection and is of interest only where symptoms of obstruction to ventilation and drainage through the nose occur. There are but few cases of the trouble today when compared to the number seen twenty years ago and, of course, the acquired anatomical defects are less. This is due in great part to better feeding and hygiene practiced more recently upon children. Some very eminent laryngologists today advise against removal of this tonsil except where breathing exercises fail to produce the desired ventilation.

The lingual tonsil is at times the source of focal infection and may cause pharyngeal irritation and a chronic hacking cough. The infratonsillar nodes are sometimes incorrectly called lingual tonsil.

The tubal tonsils, often the source of focal infection, may enlarge after the palatine tonsils have been removed and thus look much like a part of the palatine tonsil. They are located just back of the posterior pillars and extend from just below the opening to the eustachian canal to the lower part of the palatine tonsil. Too many times the surgeon overlooks the upper attachment during the operation and fails to secure the desired relief.

THE PROBLEM OF FUNCTION

We should consider function when removing specialized tissue, especially if in so wholesale a manner as the tonsil. After a great deal of study, two theories have been accepted; one, autoimmunization or protection of the body against infection and the other, hematopoietic or production of lymphosites in common with other lymphoid tissue.

Last year a very thorough and important study was completed by Sigismund Peller, of Vienna, to prove the effect on growth and health of the body by tonsils. He examined several thousand children, fourteen and sixteen years old and adults and from these data made the following observations:

(1) Tonsillectomized young people were on the average heavier than those with enlarged tonsils.

(2) Bust measurement, 2,000 girls, was about 2 cm. greater in tonsillectomized cases than in subjects with hypertrophied tonsils.

*Read before the Sixty-second Annual Meeting of the Florida Medical Association, Ocala, May 13-15, 1935.

(3) In a mixed group, living under the same geographic and climatic conditions, there were nearly twice as many tonsillectomized persons among blonds as among brunettes.

(4) Tonsillectomized maidens menstruate about one year earlier than those with hypertrophied tonsils. Peller concludes with the statement that tonsils may be regarded as a factor inhibitory to growth and that inhibitory impulses are greater from hypertrophied tonsils.

Kaiser, of Rochester, N. Y., found that there was a slight increase of bronchitis and pneumonia in tonsillectomized children.

PROBLEM OF FOCAL INFECTION

The theory of focal infection, introduced by Billings about 1910, brought to us possibly the greatest problem of the period under discussion. The tonsils are only one of a group of organs that may serve as septic foci to derange vital organs such as the heart or kidneys or cause some general disturbance, thus giving us further proof that there should be associated effort among the medical and surgical groups to secure better diagnosis and treatment for our patients.

Our opinion and our actual knowledge of what constitutes focal infection and to what extent it is the cause of disturbance in the body has changed materially during the period under discussion. With the first burst of enthusiasm shortly after 1910 and for about ten years following this date there was a wave of reckless and unwarranted removal of tonsils and teeth. The public and the profession too often made tonsillectomy the panacea for all ills. Following this period, guided by more careful investigation called research, the profession has developed a more careful method for ascertaining if the disturbance in question is from a foci of infection and, through teamwork, determining the organ or organs harboring the infection.

The past five years has brought to us a much better understanding of abnormal functions caused by faulty diet or unbalanced endocrine function which can, and do, closely simulate focal infection. There are a number of definite tests and specific symptoms to aid us in a more accurate diagnosis. By the use of these agencies and a correct analysis of our findings we will be in a better position to advise surgery to our patients, knowing that the result will warrant operative procedure. Recently pathologists, such as Dick and others, have helped solve this problem. They were able to demonstrate in their tonsil sections just how the change in structure was responsible for the focal infection. The crypts, especially near their openings, were closed by an encircling fibrosis and surrounding the tubes were a new formed plexus of blood vessels which take up the toxine and convey it to the general circulation. Most of these tonsils have a slick, glossy surface with few or no lacuna showing. Such an infection as this could have been in the tonsil from youth to old age and the body tissues take care of the poison until accident or other disease so lowered the body resistance that the body tissues could no longer carry the load.

THE SYMPTOM GROUP

The main symptom groups may be subdivided into: first, those whose complaints are local, such as frequent colds, frequent sore throat, mouth breathing in children; second, those whose complaints are not so closely related to the throat, such as enlarged cervical glands, ear trouble, rheumatism, inflammation of vital organs like the heart or kidneys, systemic disturbance causing secondary anemia and failing health. The most necessary step in such an approach is a well prepared personal history. This with a careful, accurate examination of the patient will place a more definite picture in your mind of what is going on. Teamwork among the different groups will usually be of distinct advantage to the patient.

The appearance of the tonsil can aid us very materially to determine if it harbors a chronic infection. The tonsil with the slick surface, the submerged, the red tonsil with red tonsil pillars are those which are almost certain to have a chronic infection. The large tonsil in the adult, at a time when the tonsil should be atrophied, indicates that there is a reaction to a local infection. There is one symptom, not mentioned to my knowledge, that consists of pain at the back of the neck or head, later appearing in the shoulder and then in the arm. This symptom will be mentioned or can be secured from the patient on an inquiry in a large percentage of patients suffering from a chronic infection located in the tonsils.

Inflammation of the eyes, especially of the uveal tract, and retinitis are in the majority of cases secondary to diseased tonsils, abscessed teeth or infection in the paranasal sinuses. Many cases referred for examination for glasses prove to have focal infection from one or more of

these sources and are relieved when such an infection is removed.

THE PROBLEM OF TREATMENT

The profession has definitely settled that complete removal is the most successful method of treatment for hypertrophied or for diseased tonsils. Surgical technique is not so important as complete removal. Good surgical judgment should be exercised to determine whether the patient's age or physical state will justify the operation, also the kind of operation that would prove safest for the patient. Laryngologists feel that those especially trained and actively engaged in this field should do this work. The operation should never be classed as a minor operation, for deaths occur and complications do arise that require special experience to handle where the best interest of the patient is at stake. Fowler, in a recent report of 250,000 tonsil operations, reported thirty-three deaths. I am certain a similar review fifteen years ago would have shown a higher death rate. The record of tonsil surgery compares equally well in progress with that found in any other special division or in general surgery itself. The constant ideal in tonsil surgery has been to have fewer complications, less discomfort to the patient during and following the operation and more certain relief from his trouble. I would like to say here that considerable progress has been achieved in each of these objectives. However, our ideal has not been reached for there are still tonsil stumps present and other complications do occur but not so many as formerly. Tonsil stumps are usually the result of oversight at the time of the operation but they can be a growth of the fossa subtonsillaris. This is really a small tonsil in the fossa beneath the regular palatine tonsil which cannot be seen at the operation. I have found that the LaForce method removes many of these small tonsils with the regular palatine tonsil.

A thorough study of the patient with a good preparation for the operation is as essential here as it is for any other operation and has been a factor in bringing us nearer our ideal. When this has been done, the patient makes a more rapid and satisfactory recovery, and will have fewer complications. I am convinced that some form of calcium administered before operation is of value in the preparation.

From the time that tonsillectomy became the standard operation there have been two basic methods used, dissection and the guillotine. Other methods have been introduced as the roentgen ray, which was first thought to sterilize the tonsil. This method has not proved successful except to shrink the large tonsil and does not rid the tonsil of an infection. Diathermy is more recent and has its advantage in select cases, for example, in hemophiliacs, acute tuberculous and especially in cases where isolated enlarged lymphoid bodies in the pharynx are found that are the result of chronic irritation from postnasal discharge. The length of time, several operations being required, to safely remove the tonsils and the uncertainty as to when all the tonsil tissue is destroyed has prejudiced most laryngologists against this form of operation. The pressure of the manufacturers of the apparatus or the enthusiasm of the amateur operator are usually those who recommend this method.

THE DEVELOPMENT OF TONSILLECTOMY

My experience covers the period mentioned for I did my first tonsil operation thirty-two years ago this summer. The operation common at that time was tonsillotomy, a guillotine method, and I used the Mathews' tonsillotome. This instrument is familiar to some of you. There is some difference of opinion among authors as to who introduced the first model of the tonsillotome in America. Physic of Philadelphia secured a patent on a tonsillotome in 1826. It is possible that Mathews patterned his tonsillotome about 1880 after the Charriere instrument of France, introduced about 1860. The Fahnestock instrument of Germany, designed a hundred years ago, is considered the first of the guillotine tonsil instruments and quite likely furnished the idea for Charriere. Each of these instruments had much the same principle. Physic was the first to sever the tonsil with a sliding blade instead of the sharpened rings.

About 1910 Sluder changed the plan from two sharpened rings acting scissors-wise to a ring with a blade driven by the thumb passing through the ring and severing the tonsil. The instrument met the new ideal of removing the entire tonsil. Some time before this Hill adapted the nasal snare to remove the tonsil and later Eves improved on the snare. About 1910 Tydings improved the snare, adding to it a handle or pistol grip, making it more effective. Tydings championed the dissection to meet the ideal of tonsillectomy. A couple of years after Sluder had introduced his new guillotine, Ballinger added the handle or pistol grip to the guillotine.

Beck in 1913 combined the idea of the two instruments, snare and guillotine, in one instrument. His idea was to correct the fault of such free bleeding from the sharp knife of the guillotine by using a slow cutting snare and still have the best feature of the guillotine ring. At the same time LaForce was preparing an instrument designed to limit hemorrhage built around the guillotine method and introduced his instrument in 1913. So you see modern tonsil surgery, tonsillectomy, really began in 1910 under the influence of Billings' theory of focal infection and improved instruments.

Laryngologists throughout the country were quick to see the advantage of the new instruments and tonsillectomy. Enthusiasm grew as more and more of the stumps left in tonsillotomy were removed with benefit to the patients. Up to this time our major effort was to remove obstruction caused by the large pharyngeal and palatine tonsils in which we were quite successful in relieving the backward child. LaForce's first contribution was the box adenatome. This instrument has replaced the curette and is universally used today.

As mentioned, the enthusiasm over the tonsillectomy and a wave of reckless tonsil surgery for a few years created prejudice against the operation. This has been corrected in part by better training for the operators and more thorough and improved methods of diagnosis. During the past twenty years much has been done to improve technique and find a better operation.

I have used the LaForce method, a guillotine method, for the past nine years and it is my opinion that it has commendable features. First, it is a bloodless method for in the majority of patients there is not the loss of a teaspoonful of blood from the tonsil fossa during the operation under general anesthesia. The discomfort from inflammation and swelling in the throat is less and generally there is an earlier recovery.

Hemorrhage is the most important, immediate complication and is controlled possibly best by the LaForce method. Hemorrhage accounted for many anemias following tonsillectomy before any concerted effort was made to materially limit the loss of blood from the operation. Other complications from hemorrhage are the result of blood entering the lungs causing suffocation, pneumonia and abscess. An important factor to prevent this complication, other than a bloodless technique, is the position of the patient, his head lowered. Another important factor is the depth of narcosis, either under local or general anesthesia. Where the patient is so deeply asleep that the throat reflexes are completely abolished this danger is increased. The less the hemorrhage, the more rapid is the recovery and certainly it is less rapid in patients developing secondary anemia. For more than one year in one set of operations I did not have a hemorrhage that required after-attention.

Other troublesome complications are the result of scar tissue pulling the soft palate down onto the side of the pharynx or the tongue into the fossa. This trouble is due in part to individual peculiarities that cause scar tissue to form, and in part to too much trauma during the tonsillectomy. At one time I had too many with tongue drawn into the fossa. I modified my operation by removing less or none at all of the infratonsillar nodes and plica-triangularis and had less trouble.

It is uncomfortable after the operation to have some of our patients not relieved. Many such cases are adults who have had their trouble a long time and where there is involved other lymphoid tissue outside of the tonsils which cannot be removed. We may not have found all of their trouble; other foci may be involved and should be corrected. We also may be in error as to the diagnosis; it may not be due to some foci of infection at all. We are disappointed less when we rely more on teamwork, gain in experience and judgment, and acquire a broader conception of the task before us.

DISCUSSION

H. Marshall Taylor, Jacksonville:

Dr. Ingram's contributions to the literature are always valuable. In his paper on "The Tonsil Problem" today, he has emphasized much of importance.

In thinking of the tonsil as a focus of infection it is interesting to recall that in nearly all cases of acute and chronic arthritis that pure culture of streptococcus hemolyticus can be found in the crypt of the tonsil, and this pus injected into animals will almost always produce an arthritis. This would seem to emphasize the importance of making vaccines from the tonsils removed in all our rheumatic cases.

The streptococcus viridans is the most frequent type of infection from the tonsil in cases suffering from an endocarditis. It is interesting

to know that we seldom find this type of organism in rheumatic joints.

Dr. Ingram has laid stress on the importance of taking care of the pillars of the tonsil. This important step is often utterly disregarded by those who are not qualified to do tonsillar work. This comes either through complete lack of knowledge of the subject, a lack of discretion, or an inability to do good surgery.

An injury to the pillars of the tonsil results in a cicatricial contraction which interferes with the function of the palato-pharyngeus muscle. The palato-pharyngeus muscle in contracting tilts the thyroid on the crycoid cartilage, which is a tensor of the vocal chord. If the function of this muscle is destroyed it has a very deleterious effect on the voice, particularly in relation to the control of tone.

Dr. W. Y. Sayad, West Palm Beach:

I would like to discuss this very fine paper and, also, would like to congratulate the author for the interesting manner in which he has presented the subject matter.

It is well to be skilled in performing a tonsillectomy, but it is equally important to use judgment and discretion in subjecting patients to the operation. I think the tonsil is one of the organs of the body which is more responsible for underrating the profession than any other organ that is being operated on. It, probably, has been mutilated, or has caused more sorrow, than any organ that we operate on.

The general public, I dare say, thinks that everybody who wields a knife is a surgeon in all fields of medicine. There is no more excuse for everybody doing a tonsillectomy than for everybody doing a cataract extraction. If there were as much time spent on learning how to do a tonsillectomy as is required to spend on learning how to do a cataract extraction, it would make the matter quite different.

There are two or three things about the tonsils that have caused a great deal of grief to the medical profession, insofar as a standpoint of the public is concerned. One is the wholesale removal of tonsils, particularly in children. A great many parents have an idea that removal of their children's tonsils is a necessary measure as much as vaccination for smallpox or immunization against diphtheria are necessary measures; and a great many of our clinics have fostered this feeling on the part of the public. Children should have their tonsils as long as they can keep them, unless the tonsils are really causing a very definite difficulty.

Then, there is the manner in which the tonsil and adenoid operations are performed in a great many of our clinics. It is usually considered a minor operation and it is done with little care and in such a slip-shod manner that the end results are not only unsatisfactory but quite detrimental to the patient's health and wellbeing.

Injury to the pillars is not only detrimental to laryngeal action but it, also, might affect other functions, such as hearing. We see, not only a great many injured pillars following tonsillectomy, but, also, a great many tonsils and adenoids incompletely removed, leaving behind, literally, a mutilated throat.

There are patients who will tell you their tonsils have been removed three or four times, which means that there was an incomplete and poor job done in the first place.

I have always felt that the Sluder instrument is a very inadequate instrument for removal of tonsils. It is absolutely impossible to remove all sorts of tonsils completely with this instrument. That is one reason for there being so many secondary tonsils which we find it necessary to remove again.

Lately, we have been subjecting our patients to the use of diathermy; and this method, also, has been the source of much grief to the patient, as well as to the surgeon. However, diathermy is being discarded as a means for removal of tonsils by the majority of the otolaryngologists. Tonsillectomy, as well as adenectomy, requires accurate and skillful surgical procedure; and, if it is done correctly and well, it is a very worthwhile procedure.

There is one more point that I would like to emphasize, that systemic complications, caused by diseased tonsils, are comparatively few and much less serious in the early life than they are in the adult. Therefore, I would recommend tonsillectomy in adults much more frequently than we are doing it at present. There is more to be accomplished in adult tonsillectomy than in children; and the results are much more gratifying.

Dr. W. W. McKibben, Miami:

Just a word on tonsillectomy from the pediatrician's point of view.

About one year ago there were a number of articles covering this subject in the Boston papers. They created fear in the lay mind. The

point was emphasized that an ordinary operation even by a good surgeon was dangerous because the child might die a thymic death under the anesthetic. I have been in practice in pediatrics for more than a third of a century and I, personally, do not remember a death from this cause during that time.

The question is whether the tonsil is important to the child's welfare, growth, and to prevent infection by protective lymphoid tissue. Is tonsillectomy harmless, or is there danger of hemorrhage, lung abscess, pneumonia or meningitis?

The family doctor and the pediatrician can judge from the physical history, better than by inspection of the quality or quantity of the tonsils, as to the necessity of removal. However, hypertrophy with obstruction, dysphagia and fetor-ex-ore on the one hand, and infection with tonsillitis, rheumatism, heart, otitis media, cervical lymphadenopathy (tuberculous particularly) on the other hand, are much improved by a tonsillectomy and adenotomy.

In sinusitis with chronic headaches, postnasal catarrh, asthma, tuberculosis, laryngitis, measles, pertussis, scarlet fever, diphtheria, pneumonia, bronchitis, and cyclic vomiting, the operation is often disappointing in the north, but with the climatic factor to help in South Florida the courses have been much modified.

The improvement in nutrition may not be striking unless a proper postoperative reconstruction on food and health habits is checked.

Dr. A. K. Wilson, Jacksonville:

Dr. Ingram has covered the subject of tonsils most thoroughly; his paper is a classic, a masterpiece. I would like to bring out a few points relative to classification of tonsils and to the indication for their removal. A Wassermann is classified as one plus, two plus, three plus, or four plus; each one has its own meaning. We try to classify tonsils as benign and harmful, the harmful tonsils being very large ones and chronically infected ones. Since focal infection has received so much prominence as a factor in medicine, we feel it is our duty to eliminate this infection by tonsillectomy. However this operation is more often fatal than is commonly known.

I have here a slide showing my classification of tonsils.

Class 1.—Normal, small or large, not obstructive.

Class 2.—Suspicious only, appear normal, small or large; occasional sore throat or mild tonsillitis; malnutrition; apathy; neuritis; rheumatic pain, etc.

Class 3.—Small or large, appear infected of low grade. Chronic recurrent tonsillitis or peritonsillar abscess, with systemic symptoms of class 2.

Class 4.—Tonsils high grade infection; obstructive breathing; recurrent otitis media; debilitated symptoms; endocarditis; rheumatic fevers; beginning optic atrophy, etc.

This classification will not only be a great aid in keeping our records but will help in giving the proper treatment. Classes 2 and 3 should have very careful study before a tonsillectomy is advised as sore throat, neuritis, and malnutrition often persist after the removal of the tonsils. Local and systemic medication should be used. Tonsils of class 4 should be operated on.

I believe that all so-called school cases where charity is expected to bear the expense of operation, should be of class 4.

Dr. S. A. Shoemaker, Orlando:

We certainly have been benefited and edified by Dr. Ingram's splendid presentation of this subject. I sometimes fear it has become common belief that tonsillectomy is a trivial matter and I am glad that its importance has been so well stressed here today.

The paper is quite complete, and the discussion has been really ample, but a point or two might be in place yet.

The reason I wish to say anything at all or presume to add anything to the already replete consideration of the subject, is the question of postoperative temperature. That is often troublesome. A patient will have fever, especially a child, and sometimes even an adult. To illustrate this, I recall distinctly having operated on a boy. I was called a day or two after and told that the child had high fever; he also had pain in abdomen, and they suspected he had appendicitis or possibly an attack of typhoid. I went immediately and examined the child, but could not elicit any symptoms of typhoid or appendicitis. I said, "How much water does he drink?" They said, "He does not drink any water, it hurts." They said, "Maybe he will drink water for you." I could not bribe or entice him in any way to take water. I then told them that the child was dehydrated and that he must have water, that upon the proper ingestion of fluids his fever would disappear. I said: "Give him an

enema consisting of one pint every three hours, and do it by the clock—not at random or when you think of it, but give it by the clock as you would medicine, and if his fever does not subside in fifteen hours, let me know." They gave him the water as directed and it was not long until his fever was gone and he was drinking.

This method has a double effect in that it supplies water to overcome dehydration, and it has the psychological effect of inducing the patient to drink. Most children do not like enemas and they will suffer slight discomfort in swallowing rather than take an enema. I have tried that time and again and find it to be the easiest and most practical method of reducing temperature and supplying water.

Traumatism has been mentioned in reference to damage to the pillars. I want to speak of the harm of unnecessary traumatism to the tonsillar fossa. It should be handled as little as possible. We see many patients coming in with the tonsillar fossa absolutely obliterated. There is undoubtedly too much trauma in these cases, and possibly also removal of too much tissue. I have an illustration that serves me graphically here. I knew a man who had a beard hard to shave. Shaving was painful, more or less, and he was careful in the selection of a barber. He said, "Do you know what my notion of a good barber is? My notion of a good barber is one who can shave the beard all off and leave the skin all on."

We see many people who have been tonsillectomized by an operator like a bad barber. He took out part of the tonsil and part of the throat also. It is important that the tonsil be all taken out and that the pillars and the balance of the throat all left intact.

Every part of the tonsil should be removed in toto but it is even more important that the pillars and musculature of the throat should be zealously guarded against harm.

Dr. M. A. Lischkoff, Pensacola:

So much has been said that I feel there is little I can add.

This is a very important subject because it reaches each and every one of us, no matter what specialty we are practicing. The otolaryngologist, the pediatrician, the internist, and the surgeon all have contact directly and indirectly with patients who have been tonsillectomized or are candidates for it.

Different authors give different indications for the removal of tonsils, but I think it can be best summarized under two groups (1) localized and (2) general (infection). Local infections include that large group such as recurrent tonsillitis and peritonsillitis; fauceal obstruction; otitis, otalgia, and tinnitus; voice and speech impairment; and local adenopathy. General infection includes that large group of systemic infections where the primary focus is believed to be in the tonsils.

We all feel that no tonsil should be removed until the surgeon is thoroughly satisfied that there is a definite indication for its enucleation.

Now, about the technique: I consider any method good just so it gets the tonsil all out and leaves the pillars in the throat. I prefer the blunt dissection and snare: a careful dissection of the tonsil. It is important that you get all of the tonsil and that you get nothing else. This method produces little trauma and the reaction is relatively slight. These patients get along very much better than those who have been tonsillectomized with the Sluder or by electrocoagulation.

I am glad that most of you are beginning to feel that surgical diathermy is not a good method of choice. It is only a substitute method for patients who are not good surgical risks and it should only be recommended to those who cannot be surgically tonsillectomized.

Dr. L. C. Ingram, Orlando (concluding):

As I stated, this was an extract that I gave. There are a number of things covered in the manuscript that were mentioned by some of those who discussed the paper. I feel there is no necessity for further discussing the paper since no question was raised in the discussions that is not answered in the paper.

I wish to thank those who have so kindly taken part in the discussions.

PARTIAL STOMACH RESECTION AFTER THE METHOD ADVOCATED AND PRACTICED BY PROFESSOR HANS FINSTERER OF VIENNA*

MARVIN SMITH, M.D.,
Miami.

It is wholesome and well for any science, industry or enterprise, that there should exist differences of opinion and sometimes widely divergent views upon even important principles that

*Presented before the June meeting of the Dade County Medical Society, Miami, 1935.

underlie the science or enterprise, thereby promoting progress.

In medicine as in any other line of endeavor we have those intensive, tireless, enthusiastic workers who seem not to permit their course to be diverted to the right nor to the left but push forward to their goal. Columbus discovered America in spite of reverses and the mutiny of his sailors who almost threw him overboard. Professor Finsterer is this same type of intelligent, intensive, persistent worker. His fame as a stomach surgeon has spread over every civilized country and in Europe, Asia, Africa and Australia he stands without a peer. Therefore, I feel that it is only proper for us to acquaint ourselves a little more thoroughly with the work of this most distinguished man.

It is an interesting fact that for the last thousand years the city of Vienna has been the medical center of the entire world. It was to that city that monarchs and other prominent dignitaries of Asia and the islands of the sea would migrate in order that they might receive the best medical advice. This city has surely been the cradle of medieval and modern surgery and has produced a galaxy of illustrious physicians. The famous Billroth Hospital where the renowned Prof. Billroth designed his two types of stomach resections is situated only a few blocks from the hospital where Professor Finsterer is doing his outstanding work. The street on which it stands is called Billroth Strasse and the Billroth Schilling-coin of the nation's currency in circulation at the present day may be seen on every hand.

My object in presenting this paper is not to arouse endless debate and controversy on certain points in stomach resection which have been topics of dispute for long periods of time and probably always will be, but to present in rather brief detail, Professor Finsterer's procedure in his stomach resections as I have seen him repeat it day after day, and then, as the Professor says in his broken English, with a shrug of his shoulders, "you may take it or leave it." The precision, smoothness and completeness of his technique is an inspiration to any observer.

Thirty-seven years ago Hacker and Mickulicz at their clinic performed the first gastro-enterostomies under local anesthesia. Finsterer was an assistant in the clinic at that time and from that date has gradually developed his ideas of anesthesia and his technique of partial stomach resection. He states that he is able to operate upon many more cases by the use of local anesthesia than when general narcosis is employed on account of diseases of the heart, lungs, liver, kidneys and progressive cachexia, which preclude the use of general narcosis.

Professor Finsterer does all of his stomach resections under local anesthesia because it is his belief that the chief danger in stomach resections is due to general anesthesia and its harmful results. He sends away all resection cases that come to him with a request for general anesthesia. In doing resections on pronounced obesity cases he uses ¼ of one per cent novocain instead of ½ per cent. Quoting from his work, "Anesthesia in Abdominal Surgery": "Apparent heart, lung and kidney affections, severe anemias, advanced cachexia are for me absolute indications for the employment of local anesthesia."

The dangerous collapses following bowel obstruction operations in particular, can be avoided by preventing the sinking of the blood pressure and continuing to raise it during eventration; the first he accomplishes by large quantities of normal salt solution intravenously just prior to operation and the simultaneous use of adrenalin; and in order to maintain his pressure, he employs surgical pituitrin or pituilabdal, the operation being performed under ¼ of one per cent novocain.

In 1913, Professor Finsterer wrote: (Wr. Ki. W. 1913) "Deaths from surgical shock could only be considered as cases of prolonged narcosis and could be avoided by the exclusion of deep general anesthesia," and continuing, "I am actually able to state that amongst my 2409 laparotomies including 693 gastric and 163 intestinal resections, the patients were old and cachectic and all the operations radical, I have not had one fatality from surgical shock." He also claims that dangerous atony and delayed peritonitis is practically unknown after the use of novocain anesthesia because with that agent the high grade intestinal atony is entirely absent.

Concerning another series of his stomach resections he writes, "I have not seen one fatal case from pneumonia complications among my 460 stomach resections."

Professor Finsterer anesthetizes both the anterior and posterior belly wall. He injects a one-half per cent of novocain, fan-shaped into the deep tissues from three puncture points corresponding to the lateral borders of the rectal muscles and costal arch, after the peritoneum is opened, the abdominal walls are elevated with

sharp hooks and from within on either side 10 cc. of solution is again injected into the peritoneum a handbreadth outward from the incision.

To anesthetize the posterior belly wall, withdraw the left lobe of the liver upwards by means of a wide retractor, at the same time draw the stomach downward with the right hand stretching the small omentum; next find the artery gastrica sinistra and locate its origin in the celiac axis and go upwards with the index finger towards the head. Press down on the 12th dorsal or first lumbar vertebra between the vena cava and the aorta and at this point in the soft tissue inject from 50 to 70 cc. of one-half per cent novocain, first making certain that the needle is not in a blood vessel, and thereby infiltrates the splanchnic, major and minor, of both sides. In four or five minutes, anesthesia is complete.

Operative technique: From the point of stomach resection on the greater curvature, clamp, cut and ligate in sections, the gastro-colic membrane down to the lower border of the duodenal cap and on the lesser curvature in like manner, cut through and ligate the suspensory ligament down to the duodenal cap; now cut through the cap and close it permanently. Apply large double clamps to the stomach body and resect it; close the upper half or two-thirds with a double line of sutures, then anastomose the jejunum to the lower gaping half of the stomach; attach with interrupted sutures the proximal portion of the jejunum to the stitched-over end of the gastric stump and complete the anastomosis. Finsterer emphasizes the point that if the jejunum is anastomosed in such a direction that the peristalsis is downward, instead of upward as is the case in some types of resections, that a viscious circle will be prevented. Caffein citrate as a stimulant and a very small amount of morphine as an analgesic are the medical agents used in the post-operative treatment.

The next day after a stomach resection, liquids are given and soon thereafter, the patient is put on five soft meals a day and so continued for six months.

Professor Finsterer, in conversation with the writer, stated that in a series of 1700 gastric resections for ulcer he had been able to follow up 85% of the cases and that 90% of those operated upon report relief and that they are symptom-free. It is understood that he has done approximately 4,000 stomach resections to date.

As to the incidence of gastro-jejunal ulcer following his stomach resections, Finsterer states that in one series of 800 cases that he was able to follow closely, that only two gastro-jejunal ulcers developed. The Professor holds great contempt for gastro-enterostomies. He states that 25% or more of these patients will return in from one to five years with troublesome symptoms and indeed these figures are not so different from Balfour's observation.

Professor Finsterer gave a brief summary of his work to the writer in the following words: That every ulcer case has an acid diathesis and that if the tendency to ulcer and cancer is present that the ulcer and cancer bearing area should be removed after reasonable effort medically to accomplish a cure has been made and found unavailing. That if a duodenal ulcer is left undisturbed by the short circuit operation in lieu of resection that you have the possibility of (1) morbidity, (2) possible continuation of the ulcer, (3) possible perforation of the ulcer, (4) possible fatal hemorrhage and (5) possible cancer development.

Observation has shown that sufficient HCL acid glands remain in the portion of the stomach which is left, and that they produce ample acid for digestive purposes and that rarely, if ever, does intestinal gas or pernicious anemia or cachexia follow these cases. Finsterer's plan of resection appears to be practical wherever partial gastrectomy is indicated. About twenty cases that I have done within the past two years have brought most gratifying results.

I wish now, with your permission, to illustrate this paper by exhibiting a few lantern slides showing the technique of the operation and x-ray pictures of cases made before and after the operation, and then to present a number of patients, in person, on whom this type of stomach resection has been performed.

Case Reports

D. A., age 37. Entered Jackson Memorial Hospital May 9, 1935, complaining of severe pain in the epigastrium. A diagnosis of prepyloric ulcer was made, which was causing definite stenosis and slowing of stomach emptying-time. A classical Finsterer resection was done and the post-operative convalescence was smooth, there being no vomiting or regurgitation; at the time the patient was dismissed, June 7, 1935, the result seemed very satisfactory.

Mrs. A. G., age 35. Was sick with stomach trouble for one year, diagnosed as gastric ulcer ir the pyloric end. A Billroth 11 stomach resec-



FIG. 1. X-ray study of a stomach with a large ulcer in the pyloric end, the tumor mass from which resulted in closure of the pyloric ring.



FIG. 2. Same stomach as it appeared by x-ray study several months after Finsterer resection.



FIG. 3. X-ray picture of a stomach with a duodenal ulcer and a large tumor mass resulting in marked stenosis of the pylorus.



FIG. 4. Same stomach as it appeared by x-ray study several months after a Finsterer resection.

tion was done about May, 1933. The patient made a satisfactory convalescence and enjoyed reasonable health for one year when troublesome nausea set in, but without emesis. At times, there is a little pain in or near the region of anastomosis. There is now some suspicion of gastro-jejunal ulcer. The result, in this particular case of a Billroth 11 ulcer-operation is not regarded as thoroughly satisfactory.

Mr. J. L. R., age 63. Had been a chronic sufferer from dyspepsia and indigestion for many years, at times suffering severe epigastric pain. Condition has grown steadily worse. Vomiting began about 6 months ago, which condition continued up to the time of the operation. No tarry stolls reported. Patient entered Jackson Memorial Hospital April 24, 1935. The diagnosis was chronic duodenal ulcer with good-sized tumor mass and marked stenosis. The stomach required several days to empty its contents. A classical Finsterer stomach resection was done and the patient made a satisfactory convalescence, there being no vomiting, regurgitation or other unfavorable symptoms. He was dismissed from the hospital May 10, 1935, and so far, the results of the resection seem satisfactory. Twenty-five pounds in weight gained.

Mr. B. T., age 43. Patient entered hospital December, 1933, with perforated duodenal ulcer. A posterior gastro-enterostomy was done. One year and ten days later, patient developed serious stomach symptoms again and a diagnosis of gastro-jejunal ulcer was made and the patient was hospitalized and treated for 2 months and sixteen days with no relief, after which surgical intervention was recommended and a gastro-jejunal ulcer was found penetrating deep into the meso-colon. The gastro-enterostomy was taken down and all ulcerated tissue was removed. Finsterer stomach resection was done and the results to date seem gratifying, the patient having returned to regular work.

Mr. H. A., age 59. Patient entered the hospital May, 1933, hemorrhaging from stomach. He was treated medically, improved and was discharged. About 4 months later, he returned, hemorrhaging, was treated medically, improved and x-rayed. No ulcer was found, although clinically, a diagnosis of peptic ulcer was made. At operation, ulcer was found on posterior duodenal cap, penetrating through into the head of the pancreas. Posterior gastro-enterostomy was done. The patient returned in about eight months with severe epigastric pain and the trouble was diagnosed as gastro-jejunal ulcer. Finsterer resection was performed, which is now about a year ago. Results so far seem satisfactory, all symptoms having disappeared.

Mrs. H. A., age 42. In November, 1927, the gall-bladder was removed, recovery uneventful. Patient was relieved of epigastric pain and distress for a short while.

In 1930, she came under my observation and at that time, suffered frequent vomiting. X-ray study revealed a definite stricture at the pyloric ring, giving a seven-hour stomach retention. Posterior gastro-enterostomy was performed and dense epigastric adhesions were encountered.

The patient was relieved for four years, then she returned, complaining of vomiting large quantities of bile; no gastro-jejunal ulcer could be demonstrated by x-ray study. Rest, diet and medication failed to relieve the symptoms.

In February, 1934, the epigastrium was reopened and very dense adhesions were found entangling the hepatic angle of the colon, duodenum and liver and all adjacent structures. Effort was made to release as much of this hopeless mass as possible. Patient was relieved for 3 months and then began to vomit large amounts of bile and all fluids again.

In July, 1934, she was again forced to seek relief through surgical intervention; there was no gastro-jejunal ulcer present but the bile was being forced back into the stomach by reason of the density of adhesions. The gastro-enterostomy was taken down and a Finsterer stomach resection was done and up to date the results seem gratifying, all symptoms having disappeared.

Mrs. E. K. B., age 57. Was ill with stomach trouble many years. Began to vomit daily about 1925, suffered great pressure in the stomach and was very much bloated. A diagnosis of stenosis of the pylorus was made and Billroth 11 operation was done in June, 1932. Patient experienced some relief for a few months but now is suffering again from persistent nausea; results regarded as unsatisfactory.

THE MANAGEMENT OF ACUTE HEAD INJURIES*

J. Maxey Dell, Jr., M.D.,
Gainesville.

First, I want to discuss the immediate treatment of the injured patient. Given an injured patient in the hospital, in bed, the immediate treatment consists mainly of combatting shock. A hot bed, caffeine sodio-benzoate, and the slow administration of hypertonic fluids, plus a fourth of a grain of morphine and elevation of the foot of the bed, are the measures. The shock which is a direct result of head trauma does not involve the administration of large amounts of fluid intravenously. The patient should be let alone for the first five to six hours, except for the charting of temperature, pulse, and respiration. I do not feel that blood pressure readings are of any value in arriving at a diagnosis. In this paper I am speaking of the patient who is unconscious.

I believe that Dr. Jackson of Chicago has definitely demonstrated that hypertonic glucose and saline are of no value in the treatment of increased intracranial pressure. Neither do I believe that spinal puncture is of any real value during the first six hours, and in some cases it is harmful.

When the patient has reached the sixth to eighth hour stage, we attempt to arrive at a definite diagnosis. The pulse, respiration, temperature, reflexes, state of consciousness, presence or absence of incontinence, are the most important signposts of a break in compensation.

Given a patient past the sixth or eighth hour with the signs of an extra-dural hemorrhage, an operation is indicated. To diagnose an extra-dural hemorrhage in an unconscious patient who has never had a lucid interval is sometimes difficult. The unilateral dilation of the pupil, a positive Babinski on the opposite side, or focal signs as paralysis of an extremity, are of value. After the sixth to the eighth hour, a lateral view of the skull made with a portable bedside unit may give us some very valuable information, and certainly can do the patient no harm. Practically 100% of the patients who do not reach the eighth hour would have received no benefit from a decompression. It is surprising how long a patient can remain unconscious without a break in compensation.

The patient now up to the tenth to twelfth hour, and still unconscious, should have x-rays of the base, the frontal region, and two lateral views. The important thing to determine now with the patient is when he begins to break compensation. A rising pulse, a rising temperature, extreme restlessness, continued profound unconsciousness, rapid, shallow, and irregular respiration, are all evidence of an advanced stage of intracranial pressure. Close observation of temperature, pulse, respiration, and other data, aid in determining when a patient is breaking compensation. Close observation of the patient is essential. A rising pulse rate from intra-abdominal or intra-thoracic hemorrhage, an increase in respiration from intra-thoracic damage, an increase in temperature from a ruptured abdominal organ, must all be taken into consideration. A thorough physical examination of the entire body is essential to determine and evaluate the above mentioned signs and symptoms. Perhaps in a few cases a unilateral choked disc may be of value. Bilateral choked discs are a late manifestation of intracranial pressure.

I do not believe that it is wise to obscure the pupillary reflexes with atropine in order to obtain information as to the condition of the discs—certainly not within the first twenty-four to forty-eight hours. The appearance of focal signs are sometimes of great value.

After a patient reaches the second, third, fourth, or fifth day without any break in compensation or without any evidence of a return of consciousness, plus a beginning papilledema, he should probably have an exploratory craniotomy. A patient whose unconsciousness is improving, whose restlessness is increasing, and with a slight papilledema, is usually a patient with pachymeningitis, and should probably also have an exploratory craniotomy.

Treatment consists of operative and non-operative measures. The non-operative measures consist of keeping the patient quiet, warm, with a proper food and fluid intake. Nembutal per rectum is a very satisfactory drug to control the restlessness of the patient without any effect on the pupillary reflexes and with very little effect on the respiration. The frequent turning of the patient is essential after the first eight hours. This is expressly true of elderly people. Nutrition can be carried on through the stomach tube and through the nasal duodenal tube, and

*Read before the Sixteenth Annual Meeting of the Florida Railway Surgeons Assn., Ocala, May 13, 1935.

should consist mainly of carbohydrates. The fluid intake can be adequately cared for through any of the usual methods.

I do not believe that there is any place for hypertonic glucose and saline in the treatment of brain injuries, and I think Dr. Jackson of Chicago has rather definitely proven this. Spinal puncture is such a controversial point that I do not think one would be wrong in doing or in not doing a spinal puncture, but there are certain cases which I believe are definitely harmed by spinal puncture. These cases are the cases of extra-dural hemorrhage and sub-dural hemorrhage, and especially is this true of bleeding from one of the large venous sinuses. I believe that spinal puncture is of no value, but if it is of any value, then the stilet should be withdrawn in such a manner that only a drop of fluid comes at a time. Then the fluid should be let off very slowly. Possibly it would be a good idea, if the first drops contained no blood, to remove the spinal needle, because there is danger of starting fresh bleeding above. If the first drops of spinal fluid are bloody, it might be wise to draw off 10 or 15 cc.

There has been no definite experimental work which proves that blood in the sub-dural and sub-arachnoid spaces is definitely harmful. Dr. Dandy states that spinal punctures are of no value. Dr. Mock says that they should be made. Dr. Coleman seems to favor them.

I do not feel that there is any use to discuss operative measures. The important thing is to determine when an operation is necessary and when it is not. Of course, patients with cerebrospinal fluid leaking from their noses should be operated upon as soon as possible, and a fascial graft should be placed over the cribiform plate or over the fracture line into a sinus. This probably also applies to fractures into the auditory canal. Irrigation of ears or nose with this condition is dangerous. Some attempt to keep the auditory canal clean and sterile should be made, and sterile cotton plugged loosely in the canal.

It is impossible to attempt any full discussion of the various phases of diagnosis and management of head injuries, but I believe that the consensus of opinion is that the main factor is rest, warmth, and general measures.

In closing, I should like to call attention to one thing: It is most important to make a complete physical examination of an unconscious patient in order that any other pathology may be noted. For instance, preliminary traction of a broken femur may save many regrets in the later care of the patient. Intra-abdominal hemorrhage or rupture of a viscus may demand surgery, regardless of the brain injury, but I believe that some cases of complicated intra-abdominal hemorrhage can be controlled by blood transfusions given every three to four hours. This is a very fine differential point, and I wish that I were able to give a definite statement from a large series of cases of this condition.

HYDRAMNION, HABITUAL*

Case Report

C. D. Hoffmann, M.D.,
Orlando.

According to J. Beaufays there are only six reports in the literature, including the case he presents, in which habitual hydramnion occurred. The causes he advances are either maternal or fetal and all the children in the reported cases were either dead or macerated.[1] The case herein presented is the second in four pregnancies in which the condition has happened to this mother and whether two such incidents could classify this particular case as habitual hydramnion or not, still it is rather unusual.

I shall not go into the description of hydramnious as this can easily be obtained by reference to any of the textbooks, but shall limit this article briefly to my particular case. The patient, a female, age 34 years, fourth pregnancy, was first examined by me on January 11, 1935. The last menstrual period was October 11th, a normal period of five days. She had run an apparently normal prenatal course since that date and was in good condition when first examined by me, with the exception of an extensive pyorrhea for which dental treatment was advised. The patient had had no serious illnesses with the exception of an appendectomy in 1917. Wassermann reaction by State Board was negative on January 12th, this year.

A resume of the past pregnancy record gave the following information: first pregnancy at age of 21 years, normal delivery and normal baby; second pregnancy, age 25 years, ran eleven months with an excessive hydramnious and pa-

*Presented before the regular Staff Meeting of the Orange General Hospital, Orlando, August 5, 1935.





tient delivered a monstrosity similar to the one described below; third pregnancy, full term normal delivery, normal child at age of 29 years. The patient went into labor at home about three o'clock in the morning on June 17th, four weeks prematurely. The onset of labor was accompanied by a tremendous gush of amniotic fluid, so that, unfortunately, there was no way in which the amount of the fluid could be measured. The patient was hospitalized and delivered normally at ten o'clock in the morning.

The baby was born in a condition of asphyxia livida. There were no respirations or cry. The heart beat was weak and feeble and the apex beat was in the *right* nipple area. Various respiratory stimulants were injected into the cord and the heart muscle with no avail. The baby was given carbon-dioxide-oxygen and artificial respiration with no results. The heart beat persisted for twenty-two minutes after birth although no respirations were present. The baby was born a monstrosity with a large round head, though not resembling a hydrocephalus. There was little or no neck to the body and the junction of the head and the shoulders was very stiff and posteriorly was very wide. The rest of the body was entirely normal in appearance. There was no spina bifida. The weight of the infant was five and one-half pounds.

Autopsy which was permitted on the baby showed the following: Midline incision from the sternal notch to the symphysis. The spleen was found in the left apex of the chest cavity, the liver occupying the lower left chest cavity. The heart was in the right chest cavity, lying horizontally, with the base toward the right and the apex toward the left chest wall. There was no lung tissue in either chest cavity. A curved sound was passed downward into the bronchial tube and terminated in a fusion of mediastinal tissue and pericardium. There was no bifurcation of the bronchial tube. There was no evidence of a diaphragm and the small intestines along with the large intestine occupied the inferior portions of the right and left chest cavity. The kidneys, bladder and uterus were normal in appearance and position. The weight of the liver was 110 grams; thymus 104 grams; spleen 148 grams; heart 174 grams; the normal weights of these organs are: liver 120 grams; thymus 180 to 190 grams; spleen 7.7 grams and heart 14 grams. Note the marked enlargement over normal of the spleen and heart and the comparative reduction in the size of the thymus.

This case is particularly interesting in that two such babies have been born to this mother and because of the unusual findings at autopsy of the baby.

The Following Tabulation Shows Course of Last Pregnancy.
(Note marked increase in weight each month).

Date	Weight	BP	Urine	General Condition—Advice
January 11th	133¼	128/80	Negative	Extensive pyorrhea. Usual prenatal advice; advised dental treatment and observation.
January 24th	133¾	126/80	Negative	Condition good.
February 11th	136	128/80	Negative	First fetal movement felt February 6th.
April 10th	142½	120/80	Negative	Elixir Alurate for nervousness and insomnia. General advice regarding dietary restriction.
April 29th	147	122/80	Negative	Dental attention advised. Dietary instructions.
May 18th	153	110/80	Slight trace albumin	Digifortis for faintness. Rest.
June 3rd	162¼	132/80	Negative	Distention of abdomen marked.
July 22nd	124½	120/80	Negative	Pelvic Examination: Perineum shows old lacerations, cervix large with old stellate lacerations. Uterus normal size six weeks' postpartum, slightly anteflexed. Definite nodular hard mass size of orange right fundus, probably subserous fibroid. Tubes and ovaries not palpable.

(Six weeks' postpartum examination)

1. Year Book of Obstetrics and Gynecology (1934), page 352.

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PASTEURIZATION OF MILK

The action of the American Association of Medical Milk Commissions at its recent convention in Atlantic City is noteworthy. Provision was made for permissive pasteurization of Certified Milk. This step was taken in response to an increasing demand from both physicians and laymen. During recent years there has been an alarming incidence of diseases that are or may be milk borne. Diphtheria, septic sore throat, typhoid and undulant fever are but a few of these diseases. Despite the commendable and conscientious efforts of dairymen to keep it clean, raw milk is potentially hazardous.

Proper pasteurization constitutes an additional factor of safety. There is no justification in lowering the standards for production of raw milk. Dirty milk is unsafe whether raw or pasteurized.

Experts agree that pasteurization alters the taste of milk little and the nutritional qualities less. All milk is notably deficient in Vitamin C. It is for this reason that orange, tomato juice or some other convenient source of this vitamin is usually prescribed when a milk diet is used.

Pasteurization is a process of heating milk to 145 degrees (Fahrenheit), holding it at that temperature for thirty minutes and then rapidly cooling it. If this is deemed advisable for milk produced, handled and supervised with the care given to certified milk, it would appear to be of very much more importance in the production of ordinary market milk.

Progress of milk sanitation has played an important role in the fight against disease during the past forty years. Public health officials, parents and all others interested in providing safe milk for human consumption will receive with acclaim the adoption of permissive pasteurization for certified milk.

FINANCIAL AID TO SOCIETIES

The following recommendation of the Executive Committee was adopted by the House of Delegates, May 3, 1932, at Sarasota, (Report from May, 1932, Journal of the Florida Medical Association, page 520):

"5. We recommend that the State Association give financial aid to County Societies in their efforts to rid the State of unlicensed practitioners in the following manner: That the State Association match dollar for dollar, cash deposited by component County Societies with the State Association's treasurer, this cash to be used for medico-legal activities in said counties. The total amount put up in any one year shall not exceed 50% of the total State dues paid in by that Society during the year and in cash shall not exceed $200.00 for any one year.

"Each request for such financial aid shall be considered by the Executive Committee and no request shall be granted unless authorized by unanimous consent of the Executive Committee. Money received from any component society shall be set up in the State Association's books, with a like amount of the Association's funds, to the credit of that County Society. This fund is to be under the jurisdiction of the Association's Executive Committee and no obligations are to be incurred against this fund without such obligations first being approved by the Executive Committee. Invoices of bills for such approved expenditures shall be filed with the Business Manager of the Association, covering items of authorized expenditures, and the Association's check shall be issued in payment thereof. No payment for expenditures can be made except by means of the State Association's check bearing the signature of the treasurer of the Association."

Published comments appear in the June, 1932, Journal, page 581, and in the August, 1933, Journal, page 72.

DRAMATIZED RADIO HEALTH PROGRAM

Every Tuesday at 5:00 p.m., E.S.T.

In last month's Journal, an announcement was made of a new departure in health education by radio, namely, the dramatization of programs over a network of the National Broadcasting Company by the American Medical Association. At first it was not apparent that this would be broadcast farther west than Denver, but the program has actually been broadcast over nation-wide network, including a short wave broadcast over W8XK (Pittsburgh).

As this is written, there have been six broadcasts and the audience mail response has been of such an enthusiastic character that we feel justified in asking you to make a special effort locally to get paragraphs about the program in newspaper columns by radio editors. It has been demonstrated that radio, itself an advertising medium, cannot stand alone but must be supplemented by other publicity media.

The following announcement appeared in Hygeia and will be of value to county medical societies in furnishing local publicity.

What the radio audience says:

"Clear, colorful and concise . . ." says a Wisconsin listener. "You are doing a fine thing." Calif. — "Very interesting and instructive." Wash.—"Interesting information." Penna.—"Will be looking for more." Calif.—"An excellent program and a credit to N B C." D. C.—"Helpful." Okla.—"Very much interested." N. H.—"Classes in school extremely interested." Ill.—"Every one could learn much." Ia.—"Particularly interested because I am a teacher." N. J.—"Congratulations and long life on the air." Ariz.—"Wish every body could have heard it." Mont.—"Enjoyed your program." N. Y.—"Wonderful program." Mich.—"Give us many more." D. C.—"May your good work continue." Ill.—"Privilege to listen . . ." Calif.—and many more fine letters, all of which are greatly appreciated!

"Most interesting program on the air . . ." says a Washington fan.

"We like and appreciate your broadcasts."—Colorado.

"Heard program with intense interest."—New Jersey.

Titles for December

3. Tuberculosis, Dr. Morris Fishbein.
10. Hunting Accidents, Dr. Morris Fishbein.
17. Animal Diseases in Man, Dr. W. W. Bauer.
24. Eat, Drink and Be Merry, Dr. W. W. Bauer.
31. Pneumonia, Dr. W. W. Bauer.

N B C Blue Network: WJZ — WSYR — KWCR — WREN — KWK — KSO — WBAL — WMAL — WMC — WJDX — KVOO — WKY — WFAA. Also Pacific Coast N B C Stations.

KDKA — WCKY — WENR — WIBA — KSTP — WEBC — KFYR — WTAR — WPTF — WWNC — WSOC — WIS — WSM — KTBS — WOAI — and other N B C Stations.

Short-wave station W8XK (Through KDKA).

CORRESPONDENCE

Medical Care of Injured Government Employees

To the Editor:

I am enclosing a letter received by Congressman Caldwell, Senators Trammel and Fletcher, which explains the question raised some time ago in the meeting of the Committee on Medical Economics and later in the Executive Committee meeting relative to compensation for services to employees of the W. P. A. At that time, it was reported to the Economics Committee that there had been some discrimination in the employment of doctors for this service. Senators Fletcher, Trammel and Congressman Caldwell were asked to obtain this information.

I will thank you to publish this for the information and guidance of the members.

(Signed) J. S. Turberville, M.D.,
Chairman Committee on
Medical Economics.

United States Employees' Compensation Commission
WASHINGTON

October 23, 1935.

My dear Congressman Caldwell:

Receipt is acknowledged of your recent letter enclosing a copy of the resolutions passed by the Economics Committee of the Florida Medical Association regarding medical care of injured government employees.

For your information in this respect, the following is quoted from the Commission's Regulations Governing Compensation and Medical Expense for the Works Progress Administration:

Section 9: "The Compensation Act provides that medical treatment shall be furnished by United States medical establishments where prac-

ticable, and it is necessary that such facilities be used to the extent they are available. These facilities shall not be utilized to the exclusion or disadvantage of any other beneficiary for whom they have been specifically provided. Each Compensation Officer or his local representative should confer with the officer in charge of any Federal hospital or medical service located within the State or district under his jurisdiction and ascertain to what extent such medical facilities may be utilized.

Section 10: "In locations where Federal medical facilities are not available, or where such facilities are inadequate to furnish the service required, the State Compensation Officer or his local representatives should make arrangements for medical care by reputable private physicians. State Compensation Officers will inform physicians that the Commission will pay medical fees at rates not in excess of the minimum charge prevailing in the community for similar services. The State Compensation Officer or his local representatives should contact the local Medical Societies to enlist their cooperation in selecting physicians in the locality who are especially well qualified by training and experience to render service in industrial accident cases and who desire to participate in this service under the regulations of the Commission. Under no circumstances should there be discrimination against any physician, otherwise qualified, because he is not a member of a medical society. Plans should be made to distribute compensation cases among physicians in as equitable a manner as possible. . . . . ."

The foregoing should explain the Commission's policy as far as injured employees of the Works Progress Administration is concerned. With regard to the regular employees of the Federal Government, no change has been made, and the Commission does not contemplate making any change, in the regulations governing their care when injured in the performance of official duty.

If you desire any further information on this or other subjects pertaining to compensation matters, do not hesitate to call upon me.

As requested by you, I am returning herewith the letter from Dr. J. S. Turberville and the resolutions enclosed with your letter.

Very truly yours,

(Signed) JEWELL W. SWOFFORD,
Chairman.

CONSTITUTION

ARTICLE I.

Name of the Association

The name and title of this organization shall be the Florida Medical Association, Incorporated.

ARTICLE II.

Purposes of the Association

The purposes of this Association shall be to federate and bring into one compact organization the entire medical profession of the State of Florida, and to unite with similar Associations in other States to form the American Medical Association, with a view to the extension of medical knowledge, and to the advancement of medical science; to the elevation of the standard of medical education, and to the enactment and enforcement of just medical laws; to the promotion of friendly intercourse among physicians, and to the guarding and fostering of their material interests; and to the enlightenment and direction of public opinion in regard to the great problems of State medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III.

Component Societies

Component Societies shall consist of those county medical societies which hold charters from this Association.

ARTICLE IV.

Composition of the Association

Section 1. This Association shall consist of Members, Delegates, Honorary Members, Life Members, and Guests.

Sec. 2. *Members*—The members of this Association shall be the members of the component county medical societies.

Sec. 3. *Delegates*—Delegates shall be those members who are elected in accordance with this Constitution and By-Laws to represent their respective component societies in the House of Delegates of this Association.

Sec. 4. *Honorary Members*—Honorary and retired members of the Florida Medical Association may be elected by the House of Delegates or by the Executive Committee either directly or upon nomination officially made by a component County Medical Society. An honorary or retired member shall be exempt from all dues in this Association; shall not have the right to vote; shall be permitted to subscribe for the publication of the Association at a special price to be made by the House of Delegates or Executive Committee; shall have the right to attend meetings and be eligible to such other privileges as may be granted by the House of Delegates.

Sec. 5. *Guests*—Any distinguished physician may become a guest during any Annual Meeting upon invitation of the officers of this Association, and shall be accorded the privilege of participating in all of the scientific work for that Meeting.

Sec. 6. *Life Members*—Any member of the Florida Medical Association who has been an active member of the Association for 35 years shall be made a life member of the Association and exempt from all dues.

ARTICLE V.

House of Delegates

The House of Delegates shall be the legislative and business body of the Association, and shall consist of (1) Delegates elected by the component county societies, and (2), *ex-officio*, the officers of the Association as defined in this Constitution.

ARTICLE VI.

Meetings and Sessions

Section 1. The Association shall hold an Annual Meeting during which there shall be held daily not less than two Sessions which shall be open to all registered members, delegates, honorary members, life members and guests.

Sec. 2. The Association shall hold an Annual Meeting at the place selected by the House of Delegates at the preceding Annual Meeting. The date shall be fixed by the Executive Committee with the approval of the Committee on Arrangements of the entertaining society at least four months in advance.

Sec. 3. Special Meetings of either the Association or the House of Delegates may be called by the President.

ARTICLE VII.

Officers

Section 1. The Officers of this Association are to be a President, a President-elect, three Vice-Presidents, a Secretary, a Treasurer, and an Editor of the Journal. In the discretion of the Association, the offices of Secretary, Treasurer and Editor of the Journal may be held by one individual.

Sec. 2. All Officers are to be elected annually, and shall serve until their successors are elected and installed.

Sec. 3. The Officers of this Association shall be elected by the Association at noon on the last day of the Annual Meeting, and any member shall be eligible to any office named in the preceding section, but no person shall be elected to such an office who is not in attendance during that Annual Meeting (except the Secretary, Treasurer and Editor of the Journal) and who has not been a member of the Association for two years.

Sec. 4. THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC., shall be the official organ of the Association.

ARTICLE VIII.

Arrangement for Funds

Funds for meeting expenses of the Association are to be arranged for by the House of Delegates, by an equal per capita assessment on each county society to be fixed by the House of Delegates, or by voluntary contributions or bequests, and by profits of publications. Funds may be provided by the House of Delegates to defray the expenses of the Annual Meetings, for publications, and for such other purposes as it may deem proper.

ARTICLE IX.

Referendum

The General Session of the Association may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates, and the House of Delegates may by a similar vote of its own members, or after a like vote of the General Session, submit any such question to the membership of the Association for a final vote; and if the persons voting shall comprise a majority of all the members, a majority of such vote shall determine the question, and be binding upon the House of Delegates.

ARTICLE X.

The Seal

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

ARTICLE XI.

Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at that Annual Meeting, provided that such amendments shall have been presented in open session at the previous Annual Meeting, and shall have been sent officially to each component county society at least two months before the meeting at which final action is to be taken.

BY-LAWS

CHAPTER I.

Membership

Section 1. All members of Component Societies shall be privileged to attend all sessions and take part in all of the proceedings of the Annual Meeting, and shall be eligible to any office within the gift of the Association.

Sec. 2. The name of a physician upon the properly certified roster of members, or list of delegates, of a component society which has paid its annual assessment, shall be *prima facie* evidence of his right to register at the Annual Meeting in the respective bodies of this Association.

Sec. 3. No person who is under sentence of suspension or expulsion from any component society of this Association, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association, nor shall he be permitted to take any part in any of its proceedings until such time as he has been relieved of such disability.

Sec. 4. Each member in attendance at the Annual Meeting shall enter his name on the registration book, indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of his society, he shall receive a badge which shall be evidence of his right to all the privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of an Annual Meeting until he has complied with the provisions of this section.

CHAPTER II.

General Sessions

Section 1. The General Sessions shall include all registered members, delegates, honorary members, life members and guests, who shall have equal rights to participate in the proceedings and discussions and, except honorary members and guests, to vote on pending questions. Each General Session shall be presided over by the President, or in his absence or disability, or by his request, by one of the Vice-Presidents. Before it, at such time and place as may have been arranged, shall be delivered the annual address of the President, and the annual oration, and the entire time of the Meeting so far as may be shall be devoted to papers and discussions relating to scientific medicine.

Sec. 2. The General Session shall have authority to create committees or commissions for scientific investigations of special interest and importance to the profession and public, and to receive and dispose of reports of the same: but any expense in connection therewith must first be approved by the House of Delegates or the Executive Committee.

Sec. 3. Except by special vote, the order of exercises, papers and discussions as set forth in the official program shall be followed from day to day until it has been completed.

Sec. 4. No address or paper before the Association, except those of the President and Orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject.

Sec. 5. All papers read before the Association shall be its property. Each paper shall be deposited with the Secretary when read.

CHAPTER III.

House of Delegates

Section 1. The House of Delegates shall meet annually at the time and place of the Annual Meeting of the Association, and shall so fix its hours of meeting as not to conflict with the first General Session of the Association,

or with the session held for the address of the President and the annual oration, and so as to give delegates an opportunity to attend the other scientific proceedings and discussions so far as is consistent with their duties. But if the business interests of the Association and profession require, it may meet in advance, or remain in session after the final adjournment of the Annual Meeting, or meet at the call of the President.

Sec. 2. Each component county society shall be entitled to send to the House of Delegates each year one delegate for every 20 members, and one for each major fraction thereof, but each county society holding a charter from this Association, which has made its annual report and paid its assessment as provided in this Constitution and By-Laws, shall be entitled to one delegate. Provided, that this annual report must be made to the Secretary of the State Association at least thirty days prior to the date of the Annual Meeting.

Sec. 3. A majority of the registered delegates shall constitute a quorum, and all of the sessions of the House of Delegates shall be open to members of the Association. Ample seating facilities shall be arranged for the House of Delegates, separate and apart from the seating facilities provided for visiting members of the Association.

Sec. 4. It shall, through its officers, Council, and otherwise, give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping-stone to future ones of higher interest.

Sec. 5. It shall consider and advise as to the material interests of the profession, and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical information in relation thereto.

Sec. 6. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality, and shall continue these efforts until every physician in every county of the State who can be made reputable has been brought under medical society influence.

Sec. 7. It shall encourage post-graduate work in medical centers, as well as home study and research, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

Sec. 8. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body in such a manner that not more than one-half, as near as may be, shall be elected in any one year.

Sec. 9. It shall, upon application, provide and issue Charters to County Societies organized to conform to the spirit of this Constitution and By-Laws.

Sec. 10. In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies, and these societies when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

Sec. 11. It shall divide the State into Councilor Districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each a district medical society, and all members of component county societies, and no other, shall be members in such district societies.

Sec. 12. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates, and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Sec. 13. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Sec. 14. It shall publish its proceedings in THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC.

Sec. 15. It shall select the place for the next annual meeting.

Sec. 16. Each delegate representing a component society, before being seated, shall deposit with the Association's secretary or his duly authorized representative, a certificate signed by the Secretary of his component society, stating that he has been regularly elected a delegate by the component society. All delegates shall report at the registration desk upon arrival at the state meeting, exhibit their credentials and receive instructions regarding the meeting place and time of House of Delegates.

CHAPTER IV.

Election of Officers

All elections shall be by secret ballot, unless there is but one nominee for an office when the Secretary, upon motion duly seconded and carried, is empowered to cast the ballot of the Association for the nominee. A majority of the votes cast shall be necessary to elect.

CHAPTER V.

Duty of Officers

Section 1. The President shall preside at all meetings of the Association and of the House of Delegates; shall appoint all committees not otherwise provided for; shall deliver an annual address at such time as may be arranged; shall give a deciding vote in case of a tie, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office, and, as far as practicable, shall visit, by appointment, the various sections of the State and assist the Councilors in building up the county societies, and in making their work more practical and useful.

Sec. 2. The Vice-Presidents shall assist the President in the discharge of his duties. In the event of his death, resignation or removal, the First Vice-President shall succeed him. The President-elect shall be *ex-officio* member of all committees, without the power to vote.

Sec. 3. The Treasurer shall give bond in the amount of his yearly budget. He shall demand and receive all funds due the Association, together with bequests and donations, and shall have the care and arrangement of fiscal affairs of the Association. He shall subject his accounts yearly to audit by a Certified Public Accountant, and render an annual report of his doings to the second General Session of the Association. He shall charge upon his books the assessments upon each component County Society at the end of the fiscal year, which assessments he shall collect and make the proper credit for, and he shall perform such other duties as may be assigned him. All funds belonging to the Association shall be deposited in a National Bank to the credit of the Association. No money shall be drawn from this account except by proper voucher checks, serially numbered. The expenses of the Treasurer's bond and audit of accounts, shall be paid by the Association.

Sec. 4. The Secretary shall attend all sessions of the Association and of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be custodian of all record books and papers belonging to the Association, except such as properly belong to the Treasurer, and shall keep account of and promptly turn over to the Treasurer all funds of the Association which come into his hands. He shall provide for the registration of members and delegates at the Annual Meetings.

He shall keep a record of all the legal practitioners of the State, noting their status in relation to their county societies, and upon request shall transmit a copy of this list to the American Medical Association for publication. Insofar as it is in his power, he shall use the printed matter, correspondence and influence of his office to aid the Councilors in the organization and improvement of the county societies and in the extension of the power and usefulness of this Association. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He may employ such assistance as may be authorized by the House of Delegates or the Executive Committee. He shall annually make a report of his doings to the second General Session of the Association. In order that the Secretary may be enabled to give that amount of time to his duties which will permit of his becoming proficient, it is desirable that he should receive some compensation. The amount of his salary shall be $600.00 per annum.

Chapter VI.

Council

Section 1. The Council shall consist of one Councilor from each of the twenty-one councilor districts, to be appointed by the President. The President shall annually appoint a Chairman and a Secretary and the latter shall keep a record of its proceedings. It shall, through its chairman, make an annual report to the second General Session of the Association.

Sec. 2. Each Councilor shall be organizer, peacemaker and censor for his district. He is urged to visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his doings, and of the condition of the profession of each county in his district to each annual session of the Council.

Sec. 3. The Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies or to this Association. All questions of an ethical nature brought before the House of Delegates, or the general sessions, must originate in the county society and shall be referred to the Council without discussion.

Chapter VII

Committees

Section 1. Regular committees shall be the Executive Committee (or may be called the Board of Governors); a Committee on Scientific Work; a Committee on Legislation and Public Policy; a Committee on Publication; a Committee on Medical Education and Hospitals; a Committee on Public Relations. They shall be appointed by the President as hereinafter prescribed. The Committee on Arrangements shall consist of the component society where the Annual session is to be held.

The Florida Medical Association shall be divided into six committee districts as follows: Northwest, North Central, Northeast, Southwest, South Central and Southeast districts. The *Northwest District* (A) to include the following counties: Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, Bay, Jackson, Calhoun, Gulf, Gadsden, Liberty, Franklin, Leon, Wakulla, and Jefferson. The *North Central District* (B) to include Madison, Taylor, Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Baker, Union, Bradford, Alachua, Marion, Citrus, Sumter, Hernando, and Pasco Counties. The *Northeast District* (C) to include Nassau, Duval, Clay, St. Johns, Putnam, Flagler, and Volusia Counties. The *Southwest District* (D) to include Hillsboro, Pinellas, Manatee, Sarasota, Polk, Hardee, DeSoto, Charlotte, Lee, Highlands, Glades, Hendry, and Collier Counties. The *South Central District* (E) to include Lake, Orange, Seminole, Osceola, Brevard, Indian River, Okeechobee, St. Lucie, and Martin Counties. The *Southeast District* (F) to include Palm Beach, Broward, Dade and Monroe Counties.

Section 2. The Executive Committee (or Board of Governors) shall consist of the President and Secretary, *ex-officio*, and six members, one from each district, to be appointed by the President. Upon the adoption of this amendment to the By-Laws, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereafter they shall be appointed for three years as the terms expire. This committee shall meet immediately after the adjournment of the annual session and elect their Chairman. It shall consider and act upon all matters of business pertaining to the Association in the interval between the annual meetings, and shall render a report of its actions to the second general session.

Section 3. The Committee on Scientific Work shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years and thereafter they shall be appointed for three years as the terms expire. This committee shall meet immediately after the adjournment of the annual session and elect its Chairman. It shall determine the character and scope of the scientific proceedings of the Association, subject to the provisions in the Constitution and By-Laws. It shall prepare and issue a program for each annual meeting, announcing the order in which papers, discussions, and other business shall be presented. The number of papers to be read before each annual meeting shall be left to the discretion of the Committee on Scientific Work, but no member shall be permitted to present a paper in successive years.

Section 4. The Committee on Legislation and Public Policy shall consist of the President and Secretary, *ex-officio*, and six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years and thereafter, they shall be appointed for three years as the terms expire. Under the direction of the House of Delegates, it shall represent the Association in securing and enforcing legislation in the interest of the public health and scientific medicine. It shall keep in touch with professional and public opinion, shall endeavor to shape legislation so as to secure the best results for the whole people, and shall use every organized influence of the profession to promote the general influence in local, state, and national affairs and election. Its work shall be done with the dignity becoming a great profession, and with that wisdom which will make effective its powers and influence. It shall have the authority to be heard before the entire Association upon questions of great concern at such time as may be arranged during the annual meeting.

Sec. 5. The Committee on Publication shall consist of the Editor and two others to be appointed by the President, and shall have referred to it all reports on scientific subjects and all scientific papers and discussions heard before the Association. It shall be empowered to curtail or abstract papers and discussions, and any paper referred to it which may not be suitable for publication may be returned to the author. All papers read before the Association shall be the property of the Association. The Editor shall receive an annual salary of $600.00, provided that this be paid out of the funds of The Journal.

Sec. 6. The Committee on Arrangements shall consist of the component society in the territory in which the Annual Meeting is to be held. It shall, by committees of its own selection, provide suitable accommodations for the meeting-places of the Association and of the House of Delegates, and of their respective committees, and shall have general charge of all the arrangements. Its Chairman shall report an outline of the arrangements to the Secretary for publication in the program, and shall

make additional announcements during the meeting as occasion may require.

Sec. 7. The Committee on Medical Education and Hospitals shall consist of three members to serve; one for a period of three years, one for two years, and one for one year, the vacancy created each year being filled by appointment to serve a three-year term. This Committee shall serve in this state for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

Chapter VIII.

Assessments and Expenditures

Section 1. An assessment of $7.50 per capita on the membership of the component societies is hereby made the annual dues of the Association; of this amount $3.00 shall be set aside as a subscription for The Journal. The Secretary of each county society shall forward its assessment, together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county, to the Secretary of this Association thirty days in advance of each Annual Session.

Sec. 2. Any county society which fails to pay its assessment, or make the reports required, on or before the date above stated, shall be held as suspended, and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Sec. 3. All motions or resolutions appropriating money shall specify a definite amount, or so much thereof as may be necessary for the purpose indicated, and must be approved by the House of Delegates on a call of the ayes and noes.

Sec. 4. Any county society shall have authority to remit the dues of its Secretary, to the State Association, for duties performed in accordance with the Constitution and By-Laws.

Chapter IX.

Rules of Conduct

The principles set forth in the Code of Ethics of the American Medical Association shall govern the conduct of members in their relation to each other and to the public.

Chapter X.

Rules of Order

The deliberations of this Association shall be governed by parliamentary usage as contained in Roberts' Rules of Order, unless otherwise determined by a vote of its respective bodies.

Chapter XI.

County Societies

Section 1. All county societies now in affiliation with this Association or those that may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and By-Laws, shall, upon application to the Council, receive a charter from and become a component part of this Association.

Sec. 2. As rapidly as can be done after the adoption of this Constitution and By-Laws, a medical society shall be organized in every county in the State in which no component society exists, and charters shall be issued thereto.

Sec. 3. Charters shall be issued only upon the approval of the House of Delegates and shall be signed by the President and Secretary of this Association. The House of Delegates shall have authority to revoke the charter of any component county society whose actions are in conflict with the letter or the spirit of this Constitution and these By-Laws.

Sec. 4. Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Councilor for the District if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Council, which shall decide what action shall be taken.

Sec. 5. Each county society shall judge of the qualification of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable white and legally registered physician who is practicing, or who will agree to practice, non-sectarian medicine, shall be entitled to membership. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every such physician in the county to become a member.

Sec. 6. Any physician who may feel aggrieved by the action of the society of his county in refusing him membership or in suspending or expelling him, shall have the right of appeal to the Council which, upon a majority vote, may permit him to become a member of an adjacent county society.

Sec. 7. In hearing appeals, the Council may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a Board and as individual Councilors in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Sec. 8. When a member in good standing in a component society moves to another county in this State, his name, upon request, shall be transferred without cost to the roster of the county society into whose jurisdiction he moves.

Sec. 9. A physician living on or near a county line may hold his membership in that county most convenient for him to attend, on permission of the society in whose jurisdiction he resides.

Sec. 10. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Sec. 11. Frequent meetings shall be encouraged, and the most attractive programs arranged that are possible. The younger members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official position and other preferments shall be unstintingly given to such members.

Sec. 12. At the time of the annual election of officers each county society shall elect a delegate or delegates to represent it in the House of Delegates of this Association, in the proportion of one delegate to each twenty members or major fraction thereof, and the Secretary of the society shall send a list of such delegates to the Secretary of this Association, at least ten days before the Annual Sessions.

Sec. 13. The Secretary of each county society shall keep a roster of its members, and a list of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information, upon blanks supplied him for the purpose, to the Secretary of this Association, thirty days in advance of each Annual Meeting, and at the same time that the dues accruing from the annual assessment are sent in. In keeping such roster the Secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

Chapter XII.

Amendments

These By-Laws may be amended at any Annual Meeting by a majority vote of all the delegates present at that meeting after the amendment has laid upon the table for one day.

STATE NEWS ITEMS

The many friends of Dr. T. H. Dillard of DeLand will be glad to learn that he is improving in health. He made a trip to Philadelphia during the month of October for a check-up by Dr. Ralph Pemberton.

* * *

Dr. and Mrs. George Paulk of Miami have returned from a vacation spent in Andrews, North Carolina.

* * *

Dr. C. D. Christ attended the International Medical Assembly at Detroit during the month of October. He also spent some time at the Cleveland Clinic before returning to Orlando.

* * *

Dr. Henry Hanson, State Health Officer, Jacksonville, attended the meeting of the American Public Health Association in Milwaukee, October 7-10. The meeting was well attended, being the largest since the Chicago meeting in 1928. An invitation had been presented for the Association to come to Florida. The sentiment for Florida was favorable but it was ruled impracticable because of the lack of adequate auditorium facilities. Among other things, the Association requires from 6,000 to 8,000 square feet exhibit space and many large rooms for sectional meetings.

* * *

Dr. and Mrs. Charles Allen Born of Pensacola announce their marriage which occurred at Live Oak, Florida, June 29, 1935. Mrs. Born was formerly Miss Vera Blume.

* * *

Dr. W. H. Watters of 270 Commonwealth Ave., Boston, announces the opening of the Boston-Miami Clinic, Coconut Grove, Florida, for its eleventh winter season.

* * *

Dr. J. S. McEwan of Orlando has returned from a visit of relatives in New York. He was later accompanied by Dr. Sam Puleston of Sanford on a fishing trip.

* * *

Dr. J. H. Pierpont of Pensacola has been appointed District Surgeon of the L. & N. Railroad Company, with headquarters at Pensacola, to fill the vacancy created by the death of Dr. F. G. Renshaw. Dr. W. D. Nobles of Pensacola will take Dr. Pierpont's former position of Associate District Surgeon.

Dr. A. K. Wilson and family of Jacksonville recently returned from New York City where Doctor Wilson attended the Eye and Ear Clinic for several weeks.

* * *

Dr. and Mrs. J. T. Cowart of Tampa announce the birth of a daughter, Jean Ann, on October 16, 1935.

* * *

Dr. F. G. Renshaw of Pensacola, a life member of the Florida Medical Association, died on September 11.

* * *

Dr. James S. Grable of Tampa recently attended the annual meeting of the Interstate Postgraduate Medical Assembly held in Detroit.

* * *

Dr. Frederick Oetjen of Jacksonville has again been named vice-president on the executive committee of the American Red Cross Volunteer Life Saving Corps. Doctor Oetjen has been affiliated with the lifesavers for twelve years and has held the position of vice-president for the past two years.

* * *

Dr. and Mrs. A. L. Stebbins of Punta Gorda announce the birth of a daughter, Grace Lloyd, on September 26.

* * *

Started September 1, 1935, the Jackson County Health Unit, Marianna, Florida, is a six-piece organization consisting of health officer, three public health nurses, sanitary inspector and a secretary clerk. The director of the department is Dr. Paul G. Shell, University of Tennessee, 1931. Dr. Shell received training in public health, School of Public Health, Johns Hopkins University, under provision for medical trainees for the Florida State Board of Health by the U. S. Public Health Service, completing that training on June 30th.

The department's budget, $13,000.00, is provided jointly, fifty-fifty, by the County and State Board of Health. Activities are rendered in cooperation with and under the supervision of the State Board of Health, Dr. Henry Hanson, State Health Officer.

In the early part of October, Doctors N. A. Upchurch, City Health Officer of Jacksonville, and Stewart Thompson, attended the annual meeting of the American Public Health Association in Milwaukee. Doctor Thompson read a paper before the Section of Vital Statistics. On October 8, the National Association of Registration Executives held their annual meeting at the Hotel Schroeder, Milwaukee. Dr. Thompson, president, presided.

* * *

Dr. Frank V. Chappell, University of Tennessee, 1903, was appointed and began his duties as District Health Officer, Jacksonville District, State Board of Health, September 1. Dr. Chappell received training in public health recently in the School of Public Health, Johns Hopkins University, under provision for medical trainees made available to the Florida State Board of Health by the U. S. Public Health Service. He relieves Dr. Thos. E. Morgan, who through a Fellowship in public health granted by the Rockefeller Foundation, is attending the School of Public Health, regular course, Harvard University.

Dr. H. L. Bryans, president of the Association, was in Jacksonville the latter part of October as a member of a group of important men from different parts of the State, called in conference at the request of Governor David Sholtz. The purpose of this conference was to develop a new plan for the care of transients through which additional funds may be obtained from the Federal Government.

* * *

Dr. William C. Pumpelly of Ft. Pierce died at a hospital in West Palm Beach on September 18.

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COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

At the meeting of the Dade County Medical Society, held November 1, the following papers were presented:

"Radiation Treatment of Middle Ear and Mastoid Infections," J. H. Lucinian, Miami.

"Oral Sepsis," W. C. Rentz, Miami.

DUVAL COUNTY MEDICAL SOCIETY

The Duval County Medical Society held its regular meeting Tuesday, November 5, at the Mayflower Hotel, Jacksonville. The following papers comprised the scientific program:

"Toxemias of Pregnancy—Case Histories with Autopsies," S. R. Norris, Jacksonville.

"The Use of Unpadded Plaster in the Treatment of Fractures," Charles B. Mabry, Jacksonville.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

A meeting of the Pasco-Hernando-Citrus County Medical Society was held at the Tangerine Hotel, Thursday, October 10. Dr. S. C. Harvard of Brooksville was host, providing an excellent chicken dinner. A business and scientific meeting followed the dinner. Drs. J. T. Cowart and H. J. Blackmon of Tampa were guest speakers. Doctor Cowart gave a very interesting paper on "Treatment of Vomiting in Children." The following doctors, members of the society, were present: Dr. P. J. Hudson, Crystal River; Dr. G. A. Dame, Inverness; Drs. S. C. Harvard and G. R. Creekmore, Brooksville; and Drs. W. W. Jones and John J. Bourke of Dade City.

PINELLAS COUNTY MEDICAL SOCIETY

The Pinellas County Medical Society held its October meeting in the Chamber of Commerce Building, Clearwater, on the 4th of that month. Being the end of the Society's fiscal year, election of officers was held which resulted as follows:

President—F. E. Kauffman, Clearwater.

First Vice-Pres.—Robbins Nettles, Clearwater.

Second Vice-Pres.—E. A. Heibner, St. Petersburg.

Sec'y-Treas.—W. C. McConnell, St. Petersburg.

Dr. R. H. Knowlton of St. Petersburg presented a paper on "Heart Disorders," which was discussed by Drs. Carl Williams, George Lochner and Arnold Anderson of St. Petersburg and Dr. E. Nelson, Soldiers' Home, Bay Pines.



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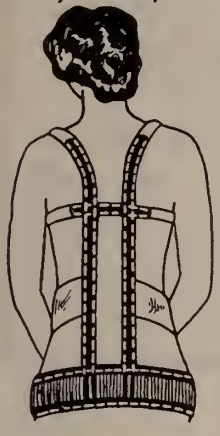
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DUVAL AUXILIARY

The October meeting of the Woman's Auxiliary to the Duval County Medical Society was held at the home of Mrs. Edward Jelks, with the president, Mrs. O. P. Broadbent, presiding.

The meeting was opened with the reading of the Collect by the secretary. Mrs. J. H. Owens, program chairman, introduced the guest speaker, Dr. F. W. Krueger. Having recently returned from an extensive trip through Germany, Dr. Krueger came well informed on his subject "Social Conditions in Germany". He stated: "Germany is a country in which the middle class predominates. There is not so much evidence of extreme wealth or dire poverty, as there is in most countries. To the casual observer there is no evidence of the effects of the war noticeable either in the people themselves or in the cities and buildings, or the country as a whole.

"It is apparent that the social problem in Germany has been far better and more satisfactorily worked out than it has in this country. The question then comes up, what is the method and what are the reasons that this is true, when fundamentally the country is not as wealthy as ours? I think the following are the chief reasons: First of all, there has always been a greater necessity for taking care of poor people and unfortunates than there has been in our country, where this problem is comparatively new; consequently their agencies and organizations for relief of the poor, unemployed, aged and unfortunates are well established, and their methods tried and proven. In the second place, there is no frequent change of the personnel of these organizations as there is in our country

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"Unemployment at present is negligible, probably due to a great extent to the fact that labor-saving machinery is discouraged and in some cases prohibited. If such devices are employed they are so heavily taxed that the revenue derived will almost take care of those people that are deprived of employment through them.

"The institution for the care of aged and afflicted, as for instance epileptics, blind and deaf are old and well established. They receive their support from the state and yet are not tempered in their management and attitude toward the patients by church supervision which in turn has state connections. Some of these institutions are immense and in them dwell such people as would otherwise be put on the streets to beg from the public. In consequence, a beggar in Germany just does not exist. Epileptic and blind people are not at large and yet in these institutions they have associations and care which makes life for them much more agreeable than it would be in their own homes and with their families while the public and the streets are not hampered with their presence.

"It is my opinion that since a country which is materially much poorer than ours can handle the social problem so satisfactorily, it should occur to us that it would be well worth our while to more thoroughly investigate their methods of handling this problem."

Following this interesting and educational discussion by Dr. Krueger, the minutes of the last meeting were read and approved. Interesting reports were heard from the chaimen of all standing committees. Mrs. S. M. Copeland expressed the desire to make the scrap book as attractive as possible this year in case we cared to exhibit it at the 1936 convention in April, when the 10th anniversary of the State Auxiliary will be celebrated. One page will be used as a memorial to Mrs. Shaler Richardson. An interesting feature will be pictures of past presi-

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dents with a record of work accomplished during their administration.

Mrs. Gordon Ira gave an interesting report on the joint meeting of the Florida State Advisory Board and the Florida State Medical Auxiliary Board held in Orlando. She urged as many as possible to plan to attend the convention in Miami in April, 1936. If 300 attend it will be possible to charter a boat for the occasion.

Mrs. Herrman Harris stressed the importance of getting Hygeia before the public. Our goal should be "Every member a subscriber or responsible for a subscriber."

Mrs. Broadbent announced that starting October 1st the American Medical Association would offer through the National Broadcasting Company a new type of program. This program will be on the air at 5 p. m. each Tuesday.

Mrs. A. K. Wilson, in discussing briefly some current medical topics of interest, said that the National University Extension Association has chosen for debate for 1935 and 1936 "Medical Service at Public Expense." Since 100,000 students throughout the United States will debate that subject the State Medical Societies should endeavor to assist debaters to secure the most dependable printed matter on the subject and an understanding of the attitude of the medical profession.

* * *

Pinellas Auxiliary

Fifteen members and guests of the Auxiliary to the Pinellas County Medical Society enjoyed the first luncheon of the Auxiliary, October 18th at the Yacht Club.

After the business meeting a musical program was given by Mrs. F. E. Burklew. The selections were "Autumn" by Frederick Guster, and "Sing On," by Denza.

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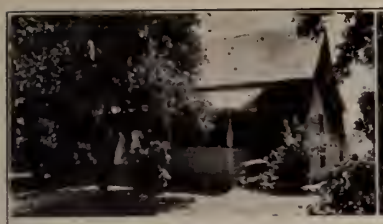
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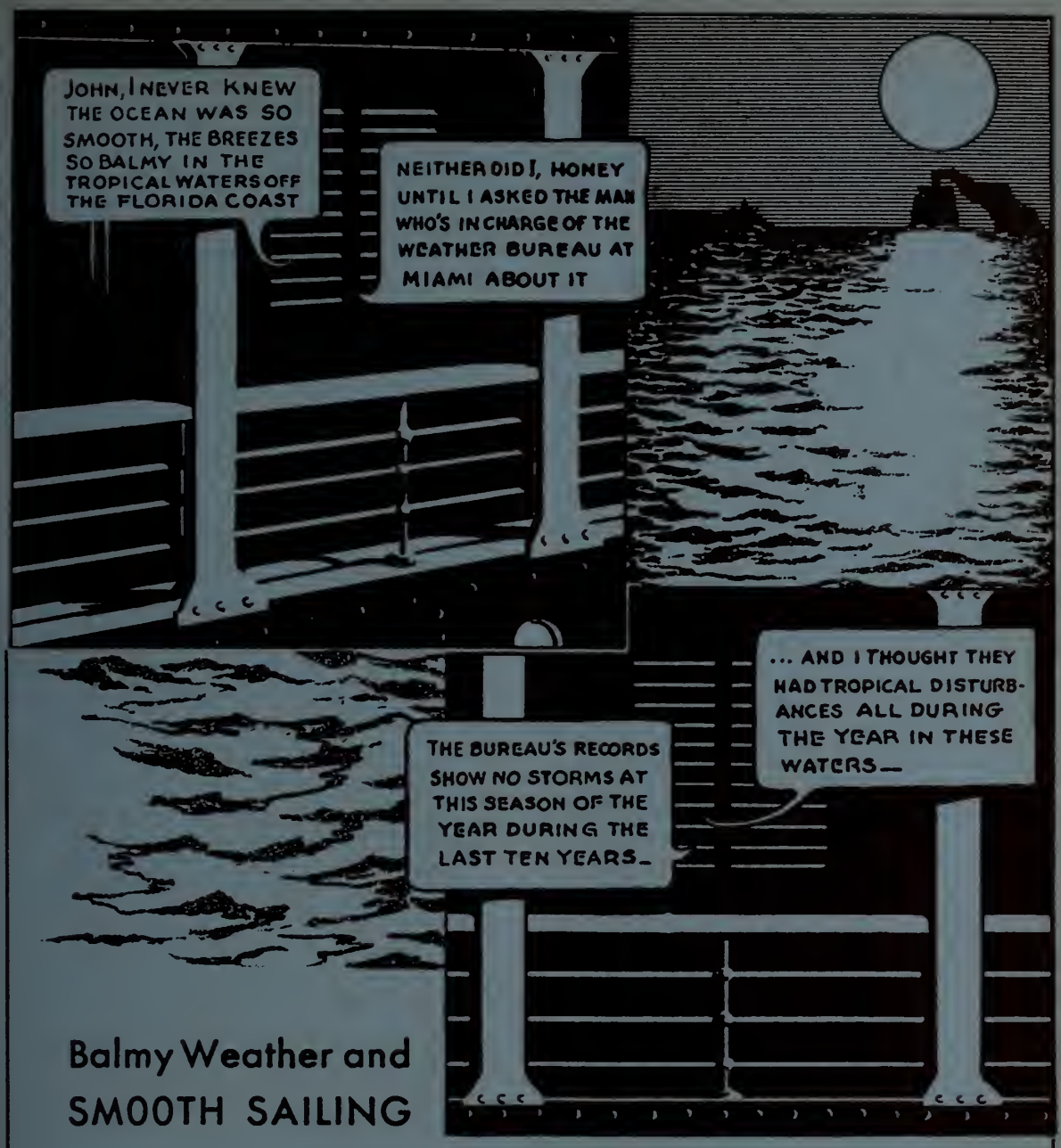
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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	J. E. Maines, Jr., M.D., 331½ W. University Ave., Gaiuesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Tuesday 12:00 noon	White House, Gainesville	23	92%
Bay	W. C. Roberts, M.D., Panama City	Allen H. Miller, M.D., Millville			8	80%
Brevard	I. K. Hicks, M.D., Melbourne	Bob Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies	7	77%
Broward	O. C. Brown, M.D., 915 Sweet Building, Fort Lauderdale	R. E. Blount, M.D., 360 S. E. 26th Ave., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale	22	100%
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	10	100%
Dade	W. W. McKibben, M.D., 316 Ingraham Bldg., Miami	Robt. T. Spicer, M.D., 1409 Huntington Bldg., Miami	1st Friday 8:30 P.M.	Club Rooms Huntington Bldg., Miami	173	98%
DeSoto-Hardee-Highlands	C. H. Kirkpatrick, M.D., P.O. Box 454 Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies	19	100%
Duval	E. T. Sellers, M.D., 412 St. James Bldg., Jacksonville	Chas. B. Mabry, M.D., Medical Arts Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	115	78%
Escambia	M. A. Lischkoff, M.D. Blount Bldg. Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola	35	90%
Hillsboro	G. C. Bottari, M.D., 1425½ E. Broadway Tampa	John S. Helms, Jr., M.D. P. O. Box 1439 Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa	110	92%
Jackson	C. C. Box, M.D., Graceville	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna	10	92%
Lake	J. D. Coupland, M.D., Eustis	W. L. Ashton, M.D., Umatilla	1st Thursday 12:30 PM.	Eustis	18	95%
Lee	Ernest Bostelman, M.D., 201 Pythian Bldg., Fort Myers	H. Quillian Jones, M.D., 18-20 Leon Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers	10	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	J. K. Johnston, M.D., Tallahassee	O. G. Kendrick, M.D., Tallahassee	Quarterly 3:00 P.M.	Varies	28	82%
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison			3	100%
Manatee	H. Gates, M.D., P. O. Box 245 Bradenton	W. D. Sugg, M.D., Bradenton Bank Bldg., Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Club Bradenton	9	75%
Marion	J. L. Chalker, M.D., 719 E. Oklawaha Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala	19	100%
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies	3	100%
Orange	T. M. Rivers, M.D., Kissimmee	J. A. Pines, M.D., 106-10 E. Central Ave., Orlando	3rd Wednesday 8:30 P.M.	Varies	51	100%
Palm Beach	W. W. George, M.D., 1116 Harvey Bldg., West Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach	53	100%
Pasco-Hernando-Citrus	A. C. Coogler, M.D., Brooksville	John J. Bourke, M.D., Dade City	2nd Thursday 7:00 P.M.	Varies	13	100%
Pinellas	W. W. Harden, M.D., 814 1st National Bank Building St. Petersburg	W. C. McConnell, M. D. 1005 Equitable Bldg. St. Petersburg	1st Friday 8:00 P.M.	Assembly Room, 5th Floor, P. & L. Bldg., St. Petersburg	75	95%
Polk	R. L. Hughes, M.D., 225 E. Main St., Bartow	J. R. Boulware, Jr., M.D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P.M.	Lakeland	67	100%
Putnam	A. E. Drexel, M.D., Palatka		2nd Thursday 7:00 P.M.	James Hotel, Palatka	6	86%
St. Johns	Reddin Britt, M.D., P. O. Box 1226, St. Augustine	John L. Bennett, M.D., St. Augustine	3rd Tuesday 8:30 P.M.	Varies	11	100%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., P. O. Box 942, Stuart	E. B. Hardee, M.D., Vero Beach	3rd Thursday 8:00 P.M.	Varies	12	86%
Sarasota	C. B. Wilson, M.D., 1st B. & Tr. Bldg., Sarasota	J. E. Harris, M.D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P.M.	Varies	14	93%
Seminole	C. L. Park, M.D 515-6 1st Bank & Tr. Bldg. Sanford	J. T. Denton, M.D., Meisch Bldg. Sanford	2nd Monday 7:00 P.M.	City Hospital Sanford	11	100%
Sumter	A. B. Albritton, M.D., Wildwood	W. E. Mitchell, M.D., Box 237 Coleman	2nd Tuesday	Varies	5	100%
Taylor	W. J. Baker, M.D., Foley	C. A. O'Quinn, M.D., Perry	Last Friday 8:00 P.M.	Dixie-Taylor Hotel, Perry	7	100%
Volusia	G. A. Davis, M.D., Dreka Bldg., DeLand	Hugh West, M.D., DeLand	2nd Tuesday 7:30 P.M.	Varies	35	90%
Walton-Okaloosa	E. L. Huggins, M.D., Freeport	A. G. Williams, M.D., Lakewood	3rd Thursday 8:00 P.M.	Varies	6	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



Balmy Weather and SMOOTH SAILING

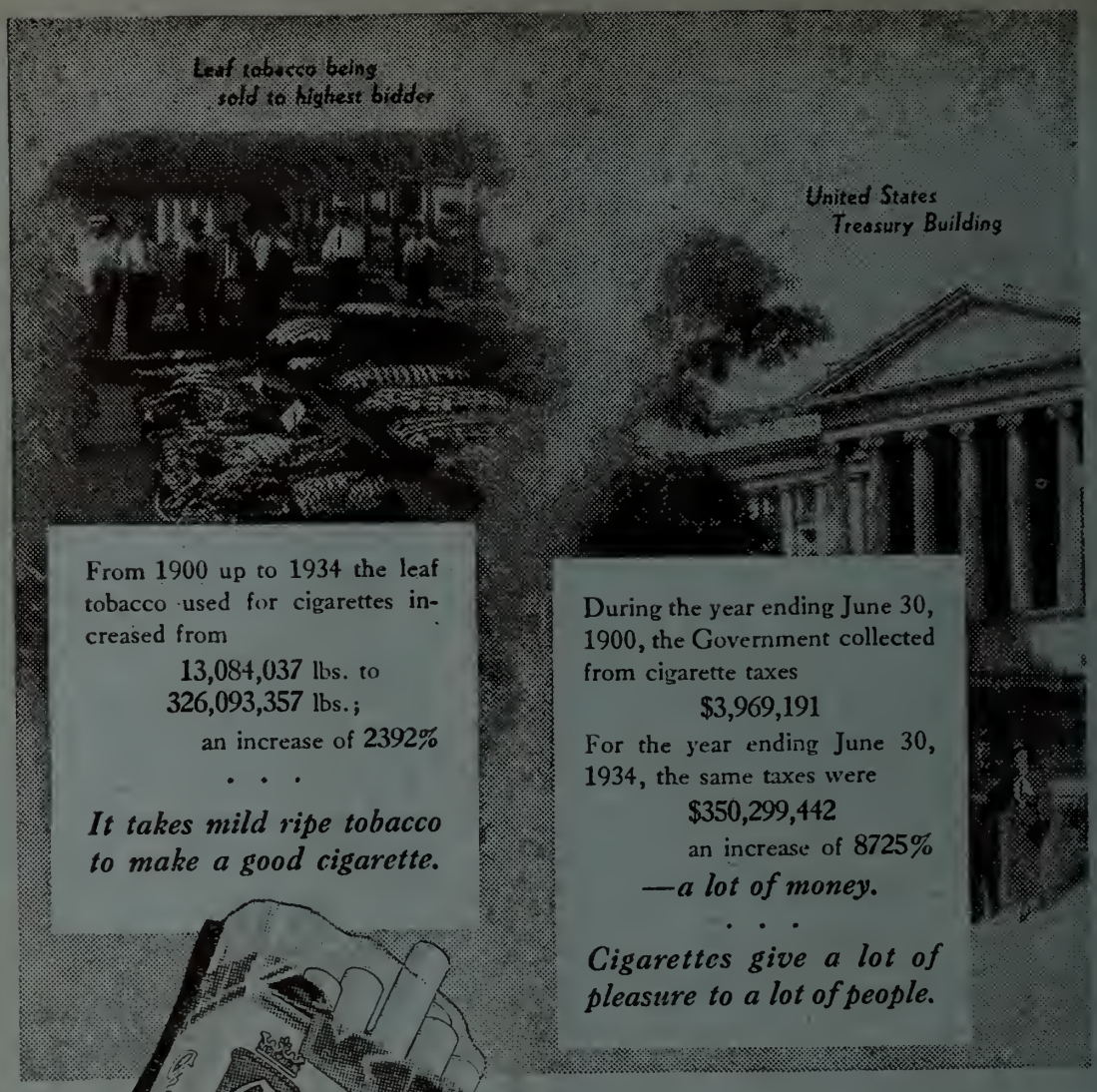
on a 3 DAY TROPICAL CRUISE

●

PLANS now under way promise smooth sailing for the Sixty-third Annual Meeting of the Florida Medical Association, Inc.

Records of the weather bureau at Miami and at Key West promise smooth sailing for the luxuriously appointed liner "Florida" on which the convention meeting will be held during a three-day cruise . . . no tropical disturbances have been experienced in the Miami-Key West area during April in the past ten years.

And the average temperature for April (73.8 degrees for Miami; 76.0 degrees for Key West) promises cool comfort in the spacious ballroom, salons and other meeting places on board the cruise ship where delegates will read, listen and talk about medical, scientific and economic subjects that will broaden their vision and add to their store of scientific knowledge.



From 1900 up to 1934 the leaf tobacco used for cigarettes increased from

13,084,037 lbs. to
326,093,357 lbs.;

an increase of 2392%

. . .

It takes mild ripe tobacco to make a good cigarette.

During the year ending June 30, 1900, the Government collected from cigarette taxes

$3,969,191

For the year ending June 30, 1934, the same taxes were

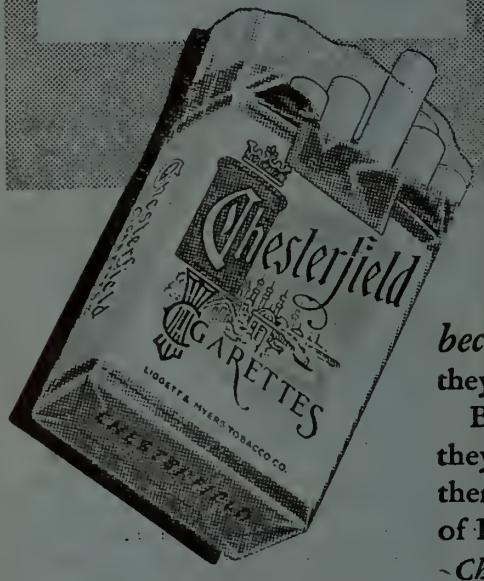
$350,299,442

an increase of 8725%

—a lot of money.

. . .

Cigarettes give a lot of pleasure to a lot of people.



More *cigarettes are smoked today because* more people know about them—they are better advertised.

But the main reason for the increase is that they are made better—made of better tobaccos; then again the tobaccos are blended—a blend of Domestic and Turkish tobaccos.

Chesterfield is made of mild, ripe tobaccos. Everything that science knows about is used in making it a milder and better-tasting cigarette.

We believe you will enjoy them.

© 1935, Liggett & Myers Tobacco Co.

NEW YORK ACADEMY OF MEDICINE
2 E 103RD ST

THE JOURNAL
—— OF THE ——
Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION, INC.

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Florida Medical Association, S.S. Florida, April 27, 28, 29, 1936.
American Medical Association, Kansas City, Mo., May 11-15, 1936.
Southern Medical Association, Baltimore, Md., November 17-20, 1936.

Entered as second-class matter under Act of Congress of March 3, 1879, at the Postoffice at Jacksonville, Florida, October 23, 1924

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AMERICAN MEDICAL ASSN.
Committee on Foods

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EFFICIENT SOURCE OF VITAMINS B and G

MEAD'S BREWERS YEAST is rich in vitamins B and G, known for their antineuritic and antipellagric properties, and nutritional essentials necessary in abundance for normal appetite and growth. Hence, it is especially valuable for supplementing diets of pregnant and nursing mothers and for breast- and bottle-fed infants, also in anorexia and malnutrition due to an insufficiency of vitamins B and G.

Weight for weight, Mead's Brewers Yeast offers 5½ times as much actual yeast as does wet cake yeast, besides having a higher vitamin content. In vitamin B potency one cake of yeast is the equivalent of 1.27 Mead's Brewers Yeast Tablets, and in vitamin G content one cake equals 1.65 tablets.

Mead's Brewers Yeast is advertised only to physicians, without dosage directions or package circulars. Servamus Fidem—"We Are Keeping the Faith."



MEAD JOHNSON & CO. Evansville, Ind.

Please enclose professional card when requesting samples of Mead Johnson products to cooperate in preventing their reaching unauthorized persons

Do Your Bifocal Patients Work for You?

THEY WILL

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They will appreciate the "Natural Vision With Comfort" you furnish for them and will sing your praises to their friends. This means increased practice and profits for you.

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PANOPTIKS ARE SOLD ONLY TO ETHICAL LICENSED PRACTITIONERS. OUR REPRESENTATIVE WILL GLADLY TELL YOU ABOUT PANOPTIKS.

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One of a series of advertisements prepared and published by PARKE, DAVIS & CO. in behalf of the medical profession.
This "See Your Doctor" campaign is running in the Saturday Evening Post and other leading magazines.



For 1936: a new outlook on life

THIS is a message to people who have been turning their backs on a very good friend the whole year long.

That friend is a *symptom*—some sign of disturbance within your body, perhaps a pain, or some other vague warning, that has been trying to say to you, "There's something wrong. May be trouble ahead. *Do* something about it."

Why carry the mistakes of the old year over into the new? Why let the neglect of the past throw a shadow over your hopes, and plans, and resolutions for the future? Before the new year dawns, *do* something about that warning. Do the intelligent thing—*see your doctor.*

He is the one person who cay say whether your trouble is a trivial one—or whether it may, if left uncurbed, seriously affect your success and happiness in the years to come.

Perhaps these past several disturbing years have drawn your nerves taut, or lowered your general resistance.

Perhaps the years have contributed too generously to your weight, thus putting an unfair burden upon your heart. Or perhaps he'll find some functional disorder which is capable of reaching serious proportions if neglected. Let your doctor decide what ought to be done.

And if he should find only some minor ailment, which will yield quickly to treatment, you'll have the thrill of getting a good bill of health from the one person who can give it. What a start for a bright new year—to be able to walk from your doctor's office, head high, unafraid, to face 1936 with the invigorating knowledge that you have the physical equipment with which to fight for the things in life you want most!

PARKE, DAVIS
& COMPANY
DETROIT, MICHIGAN

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The World's Largest Makers
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NEW closed back designs in Camp Post-operative and General Supports have been developed scientifically to meet the demand of many doctors and users who prefer the closed back for needs different from those covered by the laced back type.

The one shown (Model B-83) not only gives abdominal support, but also provides Sacro-iliac rigidity. It is easily fitted, especially where a pad is needed.

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Sold and fitted upon recommendation of physicians and surgeons by leading department stores, surgical houses, and corset shops everywhere. Write for Reference Book for Physicians and Surgeons.

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MODEL B-83





CLEAR LAKE LODGE

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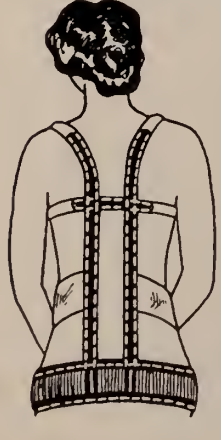
With our enlarged accommodation we are in a better position than ever to care for your invalid and neurological cases.

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GRACE H. LOCHMAN, R.N.,
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Taylor Spinal Brace, $15.00



Constructed of Surgical Spring Steel, well padded with felt, and covered with leather. Furnished with reinforced front pad and perineal straps.

Made to Order in 24 Hours

Take measurements around iliac crest, umbilicus and chest, distance from sacrolumbar articulation to seventh cervical vertebrae prominence.

WE ALSO MAKE:

Sacrolumbar Belt	$4.50
Abdominal Belt	3.50
Ptosis Support	4.50

Take measurements around the hips three inches below the iliac crest on all Belt orders.

Long Leg Brace	$20.00
Short Leg Brace	15.00
Shoulder Brace	2.50
Walking Caliper	17.50
Walking Iron	1.00
Knee Gage	20.00
French Truss	3.50
Hood Truss	4.00

Otto K. Becker Company

911 Fifth Avenue HUNTINGTON, W. VA.

Send for Illustrated Catalog.

Sacro-Iliac Belt, $3.00



Made of six-inch orthopedic webbing, well reinforced. Take measurements around the hips three inches below the iliac crest.

25% to 75% More FOOD VALUE WITHOUT INCREASE IN BULK



WHEN patients "won't eat enough," use Klim to increase the caloric value of what food *is* taken. Blend Klim with soups, cereals, vegetables or desserts. Each tablespoonful supplies 42 *extra* calories with little change in appearance, taste or bulk. For example, a tablespoonful of cream of chicken soup, usually 18 calories, contains 33 calories when fortified with Klim.

¶ Most important, with Klim you add extra food value in the form of *milk*—for Klim is nothing but powdered whole milk made more easily digestible by the drying process. Convalescents particularly will benefit from this greater milk intake.

Patients, too, will appreciate the wide variety of foods with which Klim can be blended. So different from the highly-sweetened, quickly cloying "invalid drinks."

¶ Send for a copy of the booklet "Reinforced Diet Recipes." It contains 70 recipes for preparing Klim-fortified staple dishes which provide 25 to 75 per cent more food value without increase in bulk. As many copies as you wish of this useful booklet will be sent you for distribution to patients.

KLIM

ACCEPTED AMERICAN MEDICAL ASSN. Committee on Foods

THE BORDEN COMPANY
Dept. 321, 350 Madison Ave., New York City

Please send me copies of the booklet "Reinforced Diet Recipes With KLIM."

.....M.D.

Street .....

City ..... *State* .....

THE TIN CONTAINER

● The simple facts about many things encountered in everyday life are sometimes not understood and, frequently, their values are not fully appreciated by persons thrown in daily contact with them. Among such things, we can include the so-called "tin cans" and the foods which they may contain.

For example, many may have wondered—but, certainly, few have inquired—as to the origin of the popular designation for tin containers. The name "tin cans" arose from an abbreviation of the term "tin cannisters" applied to them during the latter part of the last century by English manufacturers. Such a name is hardly correct, since "tin cans" are made from mild steel which has been rolled into thin sheets and coated with pure tin. Actually, the can is about ninety-eight percent iron.

Again, interest has sometimes been expressed in regard to the nature and purpose of the enamels found in cans in which certain products are packed. These enamels are essentially lacquers developed by years of intensive research; they are baked on the tin surface at high temperatures. Their chief purpose is to preserve natural flavor and color characteristics of some foods. While desirable in certain instances, enameled cans are not necessary to insure a wholesome canned product.

The facts about the foods contained in cans are equally simple. Canned foods are merely selected foods which, after preparatory operations, are hermetically sealed in tin containers from which most of the air has been excluded. The preservation of the foods is then effected by a heat treatment.

The nutritional values of commercially canned foods have been established by more than a decade of biochemical research. Reference to recent articles (1), (2), together with those publications listed in their bibliographies, will permit the reader to determine for himself how favorably commercially canned foods have stood the test of actual scientific scrutiny.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) 1934. Ind. Eng. Chem. 26, 768
(2) 1932. Ind. Eng. Chem. 24, 660

This is the seventh in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

ACCEPTED AMERICAN MEDICAL ASSN. Committee on Foods

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Committee on Foods of the American Medical Association.

Shrinkage of the Turbinates Effected by Benzedrine Inhaler In the Treatment of a Common Cold



Figure 1— Time, 2:15 p. m. Before treatment.

Case No. 1 (C. S.) Male, white, age 25. Acute head cold of two days' duration, seen at the Nose and Throat Clinic of a Philadelphia hospital, February 13, 1934. After a few inhalations from Benzedrine Inhaler the turbinates were shrunk to normal within seven minutes. Passage of air was possible and the patient was greatly relieved.

Figure 2—Time, 2:22 p. m. After using Benzedrine Inhaler.

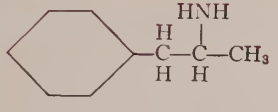




BENZEDRINE INHALER

Each tube is packed with benzyl methyl carbinamine, .325 gm.; oil of lavender, .097 gm.; and menthol, .032 gm.

ACCEPTED AMERICAN MEDICAL ASSN. Council on Pharmacy and Chemistry



A glance at the formula of Benzedrine (benzyl methyl carbinamine) will show that it has the fundamental grouping which causes shrinkage of engorged nasal mucosa. Additional advantages are:

(i) Its effect is adequate and persistent.

(ii) It is volatile, providing easy application and prompt action without irritation or secondary effects.

A new vasomotor constrictor with a potency equal to or greater than that of ephedrine. For shrinking the nasal mucosa in head colds, sinusitis, vasomotor rhinitis, hay fever and asthma.

SMITH, KLINE & FRENCH LABORATORIES

PHILADELPHIA, PA.

ESTABLISHED 1841



your patients will appreciate its CONVENIENCE

. . . when you prescribe Benzedrine Inhaler in common nasal conditions

The little aluminum tube can be carried in pocket or handbag to bring relief in the midst of business or social activities. No atomizers, sprays, droppers, etc., are required, and the necessity of retiring for treatment is eliminated.

Because it can be used inconspicuously at any indicated time, the inhaler encourages the full cooperation of your patients.

Effective—Benzedrine represents a distinct chemical and therapeutic advance. Possessing the fundamental grouping which causes shrinkage of engorged nasal mucosa, it exhibits in vapor phase a potency equal to or greater than that of ephedrine. It does not cause atony, bogginess or secondary returgescence even on continued use.

Economical—A recent prescription survey conducted by us has shown that the cost of one Benzedrine Inhaler is *approximately one-half that of an ounce of standard solutions of ephedrine.*



BENZEDRINE INHALER

ACCEPTED AMERICAN MEDICAL ASSN

Each tube is packed with benzyl methyl carbinamine, .325 gm.; oil of lavender, .097 gm.; and menthol, .032 gm.

SMITH, KLINE & FRENCH LABORATORIES

PHILADELPHIA, PA.

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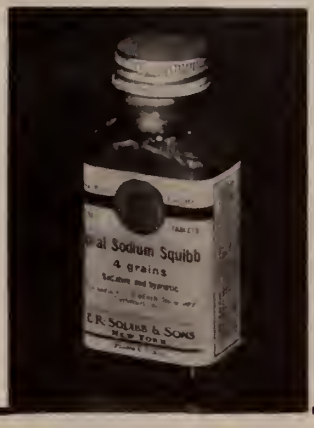


ANTICIPATION OF A SURGICAL OPERATION often induces great apprehension in patients which in turn robs them of sleep—drains their resources—creates anxiety and increases the surgical risk. For these patients the administration of a safe sedative or hypnotic brings welcome relief and freedom from fear.

IPRAL SODIUM (sodium ethylisopropylbarbiturate) is a safe sedative and hypnotic which induces refreshing sleep closely resembling the normal. It is readily absorbed, rapid in action, of low toxicity and effective in small therapeutic doses. When administered in therapeutic dosage no untoward organic effects have been observed. Supplied in ¾-gr., 2-gr. and 4-gr. tablets.

For conditions where pain accompanies insomnia, the use of IPRAL AMIDOPYRINE (2 gr. Ipral, 2.33 gr. Amidopyrine) is desirable to fortify the patient against pain, as it provides both an analgesic and a sedative effect.

Both of these Squibb Ipral Products are supplied in bottles of 100 and 1000 tablets. For descriptive literature address the Professional Service Department, 745 Fifth Avenue, New York City.



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MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

Makers of INSULIN SQUIBB

YOU CAN'T PRESCRIBE

BETTER *Bifocals*

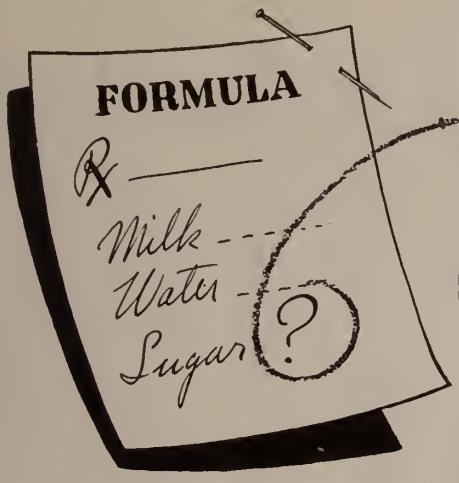
There is an American Optical Company Bifocal to fulfill every requirement demanded of a double vision lens.



Here are three bifocals that are color-free, corrected and modern in every detail. Each has particular merits which recommend it in individual cases . . . PANOPTIK Bifocals offer a lens form in which almost any bifocal requirement, however complicated, can be incorporated . . . FUL-VUE Bifocals provide an improved style which minimizes jump and visual confusion . . . TILLYER "D" Bifocal's inconspicuousness is an important factor when the cosmetic effect must be considered... Here are three outstanding lenses to choose from when bifocals are indicated.

BVI AO

American Optical Company



How much Carbohydrate for the Formula?

Some physicians don't realize that volume for volume, Karo Syrup furnishes about twice as many calories as a similar sugar modifier in powdered form.

Try this Saturation Test . . .

Add a little water to a level tablespoonful of any powdered maltose-dextrin-dextrose and warm over a Bunsen flame. The full tablespoonful of powder shrinks to about one-half of a tablespoonful of syrup.



Karo Syrup contains twice as many calories as . . . . .



Powdered Maltose-Dextrins, including Karo Powdered

KARO is already saturated with maltose-dextrins-dextrose, which is why it is so rich in calories. A tablespoonful of Karo Syrup yields approximately sixty calories, while a tablespoonful of powdered maltose-dextrins-dextrose gives approximately twenty-nine calories. In using Karo Syrup remember its high caloric value. You may follow our Karo formulae devised by eminent pediatricians. But if you use formulas calculated for similar sugars in powdered form, only half the number of tablespoonfuls of Karo Syrup are necessary to furnish the same caloric value of carbohydrate.



The 'Accepted' Seal denotes that Karo and advertisements for it are acceptable to the Committee on Foods of the American Medical Association.

ELI LILLY AND COMPANY

FOUNDED 1876

Makers of Medicinal Products



The "Sheet Anchor"
IN DIABETES MELLITUS

The absence of pathologic change in the pancreas of some diabetics has suggested the hypothesis that diabetes mellitus may have an extra-pancreatic origin in certain patients. Although the thyroid, the adrenals, or the pituitary gland may be implicated in such cases, Insulin remains the "sheet anchor" in the management of diabetes mellitus.

The purity, stability, and uniformity of Iletin (Insulin, Lilly) are characteristic. It is supplied through the drug trade in 5-cc. and 10-cc. vials.



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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXII | Jacksonville, Florida, December, 1935 | Number 6

BOILS AND CARBUNCLES*

J. R. CHAPPELL, M.D.,
Orlando.

Boils, technically described as furuncles, are a source of considerable annoyance to practically every branch of the medical profession, as well as being a source of extreme annoyance and discomfort to the patient, particularly that type of boil which occurs in series or crops. Almost every specialist in the medical profession is at some time or other called upon to treat boils, surgeons, pediatricians, dermatologists and radiologists, ear, nose the throat men, ophthalmologists, gynecologists, the medical men and the general practitioners. Suffice it to say that for as many different doctors as are called upon to treat boils, there are ten times as many different treatments. One is indeed surprised at the voluminous amount of literature that is to be found on the subject. Every author has his favorite way of treating the malady, and each one seems to think that his way is the best. With one exception, they all agree that boils of the upper face are extremely dangerous, and should be treated with considerable care and caution.

A furuncle, as described in Delafield and Prudden's[1] text book on Pathology, is an acute circumscribed suppurative and necrotic inflammation of the skin, with necrosis involving a central plug or core. They are usually incited by a staphylococcus pyogenes aureus, and occasionally by the streptococcus pyogenes. The invasion of the staphylococcus is usually through the glands and hair follicles. If the infection of several contiguous hair follicles, either immediately or in rapid succession, take place so there are several centers of necrosis with surrounding areas of inflammation, the resulting lesion is called a carbuncle. These may be experimentally induced by rubbing pure cultures of staphylococcus over intact skin.

Bessesen[2] describes the distinction between the furuncle and carbuncle as being anatomic and not pathological. He states that the furuncle is an infection of the skin and subcutaneous tissue without close connection between the skin and underlying fascia. The carbuncle occurs in portions of the body where the skin is closely attached to the fascia by dense fibrous strands, as in the hairy portions of the body, particularly on the back of the neck. This infection, instead of producing the conical swelling customary in boils, makes the connective tissue taut, and forces the infection laterally, producing widespread necrosis under a plateau-like elevation of the integument.

In reviewing the literature describing the treatment of furuncles and carbuncles, one finds that the authors are generally divided into those who favor incision and those who oppose it. Objections to the incision of furuncles are numerous. They consist almost entirely of fear of the possibility of opening new channels of infection; the associated pain in the opening of a furuncle or carbuncle; the slow healing; the use of a general anesthetic, which only applies to carbuncles as it is seldom necessary to use an anesthetic for incising a furuncle; and the disfiguring scar which usually results from such procedures.

Among those who object to employing surgery in carbuncles and furuncles is Junkerman,[3] who regards incising a carbuncle or boil before fluctuation as criminal. Others are Pulay,[4] Morian,[5] Friedeman[6] and Dittrich.[7] Morian[5] states that in furuncles of the face, no better results are obtained by incision than by conservative treatment, and the disfiguring scar is thereby avoided. With this statement, one is inclined to disagree as it seems reasonable to think that as a general rule scars resulting from spontaneous rupture are much more disfiguring than those left by a shap incised wound.

Dittrich[7] found that in 22 of 40 cases of furuncle of the upper lip which were treated by incision, the mortality was 13.6%, whereas, in 18 cases in which incision was not done, the mortality was only 5.5%.

Melchoir[8] collected 73 cases of furuncle of the face. In this series, there were 36 cases treated

*Read before the Sixty-second Annual Meeting of the Florida Medical Association, Ocala, May 13-15, 1935.

conservatively with but one death. There were 37 cases treated by incision with four deaths. However, he states that incision was done in the most serious cases. He is inclined to think that if the process does not respond to conservative treatment, incision is the safest procedure.

The chief danger of furuncles of the upper face is cavernous sinus thrombosis, an infection by way of the facial vein (Hinton.[10]) H. J. Jurgens[11] believes that there are four reasons for this danger; first the anatomical make-up of the parts involved; second, trauma; third, absence of physiologic rest; fourth, the facility for rapid multiplication of the infecting organism. Cavernous sinus thrombosis is a result of the infection being disseminated by the blood vessels of the upper lip into the anterior facial vein through the superior labial vein, and from there into the angular vein which later empties into the superior ophthalmic. This vein empties into the cavernous sinus. The venous blood of the upper lip may empty into the main trunk of the anterior facial vein which later empties into the internal jugular vein. The venous blood from the nostril enters the superior longitudinal sinus. Infection may enter the blood stream by direct extension of the cellulitis and lymphangitis. Therefore, there are four routes of infection which may cause complications of the infection of the upper face.

Jurgens[11] states that, in his opinion, all infections about the face should be treated in the beginning by abstinence of all radical methods. Of course, the pernicious habit of trying to open and squeeze the infection should be warned against, and a plan of treatment outlined which places the part as nearly as possible at physiologic rest, by prohibiting speaking and the mastication of solid foods. He advocates the use of hot moist applications. If, in spite of this, the infection travels onward involving the superior longitudinal sinus, then the condition is hopeless. But, if it should travel through the ophthalmic vein which can be recognized by a red round swelling up the grooves of the nose, ligation of the vein just below the inter-canthus should be done. Should the infection follow the anterior facial vein on its way to the internal jugular, which may also be recognized, then this vein should be ligated at the angle of the jaw.

Among those who favor the incision of boils and carbuncles are Lee and Downes[12], who believe that there are two indications for treatment of all pyogenic infections; the relief of tension, and the removal of dead tissue. Livingston,[13] studying 160 cases of carbuncles of the back of the neck admitted to Bellevue Hospital, advises immediate excision of the necrotic tissue. Excision is advised by Goldschmidt,[14] Franke,[15] Edmunds[16] and Axhausen.[17]

Werner Schmidt[18] states that statistics are misleading, due to the fact that surgical treatment is charged with the hopeless cases to begin with. He states that incipient furuncles and benign furuncles must by all means be treated conservatively, but malignant furuncles should be treated surgically and radically by excision in toto. This statement is made of the facial furuncle. He states that the venous ligation can be done with the extirpation, if necessary. He stresses the advantages of the electric bistoury which are: scant if any bleeding; easy hemostasis; occlusion of lymph spaces, reduction of absorption, and hence less shock; slight postoperative pain, etc. He states he has had no fatalities in 22 cases of the severest occipital carbuncles and many malignant facial furuncles, while in 22 cases which he did not excise, he had three fatalities. He recommends conservative treatment in the benign cases, that is, as long as they are benign, and particularly stresses the use of insulin.

De Keyser,[19] writing in "International Clinics," 1930, recommends the oxygen treatment for boils and carbuncles. He introduces a needle into the opening of a furuncle. When the opening is delayed, he hastens it by hot applications of hot compresses which have been wrung out in oxygenated water or solution of hydrogen peroxide. He states that this procedure is without pain. The needle is attached to a tube which is in turn attached to an oxygen cylinder. The amount of oxygen used is tested first by immersing the needle in water. After the needle has been placed in the furuncle, he allows the oxygen to bubble through for several minutes. He states that the furuncle is cured in from three to four days; that a carbuncle is slower to cure, but easily takes place in about 15 days. He does not claim that the oxygen destroys the staphylococcus, but states that the oxygen brings about an augmentation of the phagocytic power of the white blood cell, and as a result the purulent condition is overcome. Many writers approve vaccine therapy; others, particularly William A. White and Edward A. Cooney[20] are in favor of foreign protein therapy. They state

that protein injection favorably activates cell stimulation, and increases the specific protective antibody, thus aiding nature. They use aolin, omnadin and activin, but prefer aolan, and their description of the results obtained are quite glowing. I quote: "One is greatly impressed by the rapid local response to the treatment; all stages in the cycle are affected. There is early demarcation of the lesion and abrupt limitation of extension. Intensive reddening and tumefaction are followed in a few days by softening, central necrosis and sinus formation. The liquifaction is astonishing, the carbuncle seeming literally to melt away." I have had no such results in my experience.

Many men recommend x-ray for the treatment of furuncles and carbuncles. George Clinton Andrews[21] recommends the x-ray, also the ultraviolet. He also uses the electric cautery and electrocoagulation when it becomes necessary to open the infection.

R. A. Silva,[22] of Buenos Aires, reports eight cases of carbuncles cured by the injection of what he calls Mendez Carbuncle Antitoxin. According to his reports this antitoxin must be marvelous. I have had no experience with its use.

George E. Pfahler,[23] reporting his personal experience with boils, concludes that they are due to an excess of carbohydrates. He found that his series of boils usually followed a heavy carbohydrate meal, and he recommends testing of the urine for sugar; testing of the blood for excess sugar; reducing the carbohydrate food to a minimum, as long as there is any tendency to boils; removing all source of focal infection; local applications of tincture of iodine to the initial lesion, allowing the iodine to dry between applications, and massaging the area around the lesion thoroughly from five to ten minutes, three to four times a day. He does not recommend incising them.

Bieber,[24] who investigated blood sugar in furunculosis, states that two units of insulin, daily, for two days will cause the furuncle to disappear. Good results in furunculosis, with the use of 20 to 80 units of insulin in non-diabetics, is reported by Stormer.[25]

Levin[26] states that it is unnecessary and very unwise to incise a boil; instead, he recommends the rational treatment consisting of various drugs and agents on the inflamed area to promote discharge, destroy infection and restore, as near normal as possible, the diseased area.

Winckler[27] advocates the use of a Paquelin cautery. He states that everything depends on its correct application. First of all, he says, the point should be brought to a white heat so that it may be introduced easily and rapidly into the depth of the infectious focus. It must be introduced perpendicularly exactly in the center, in order to destroy the necrotic core. To do this, he recommends using a metal disk, perforated in the center by a small hole. The disk is placed on the furuncle with slight pressure, so that the apex bulges into the opening. In this manner, the cautery is introduced. He states that with small furuncles, one prick into the cellular tissue is sufficient. For furuncles or carbuncles of the upper face, he recommends the same treatment.

D. W. Bruce[28] recommends the injection of whole blood for furunculosis, particularly the recurring type. He withdraws 5 cc. from the median basilic vein, and immediately injects it into the gluteal muscles. He states that this causes boils to dry up within 24 hours and prevents further formation of boils. In only one case was a second inoculation found necessary.

W. Anthony Ball[29] recommends giving a thyroid extract, grains ½ and potassium permanganate, grains ⅛ which treatment, he states, was initiated by H. W. Nott. He also uses a mixture of iron and arsenic in tablet form, given by mouth.

Laewen,[30] following four fatal cases of carbuncles in which extensive incision had been done, began using injection of the patient's whole blood, injecting at the margin of the induration after crucial incision. He states that results were favorable. This method has been reported as successful by Linhart,[31] Carp,[32] and others.

It is impossible to enumerate the various agents that have been employed in furuncles. Vaccines, of course, have been long employed, but the results, according to most authors, are unfavorable. Sulphur has been used in homeopathic doses. Bier[33] recommends sulphuric iodide, three times daily. Tin, of course, has been used quite extensively for the past few years. It was first recommended in 1917 by Frouin and Gregoire.[34] They used the chloride or oxide, and marketed it under the name of stannoxyl, which is composed essentially of metalic tin and tin oxide. Personally, I have

had very little success with its use and the literature does not justify the claims made for its success when it was first introduced. Various ointments, as Gray's ointment, icthyol ointment, etc., have been used frequently and will continue to be used, both before incising and after incising.

No paper on boils and carbuncles could be complete without a few words regarding the prophylactic treatment. Trauma plays an important part in the formation of boils and carbuncles. Trauma should be carefully avoided, particularly by men who wear stiff collars, causing skin friction (Christopher.[9]) Shaving with a dull razor traumatises hair root follicles, and should be avoided. In diabetics, dietary precautions should be carefully watched. Strict body cleanliness aids in the prevention of boils, particularly in those people who perform manual labor. These people perspire heavily, and as the staphylococcus is constantly found on the skin surface, the open pores of the skin afford easy access for infection. Athletes are peculiarly susceptible to boils and carbuncles. I have noticed the frequency of furuncles in baseball players in their spring training season, and I think it is due largely to the body massage which these athletes receive by trainers, following their workout. They return from practice, remove a sweaty uniform and are immediately given a body massage before taking a shower. Cleansing baths before the massage and the use of a strong antiseptic solution, preferably an alcoholic solution as a massaging agent, aids materially in preventing skin infection.

Bessesen[2] makes a statement that he has never seen a severe skin infection in a well tanned individual. This should be of great interest to the people of Florida who are exposed to the sun so frequently. Since the dark sun tan has become so popular, it may prove of considerable benefit to the people of this state. I can readily agree with him in this statement that a good sun tan aids in the prevention of skin infection.

Each furuncle and each carbuncle is a separate and distinct problem in itself. The high mortality of upper face infection makes it unwise to use any radical procedure, but I am of the opinion that infections of the upper face, after fluctuation is present, can be opened with the endotherm or Paquelin cautery or glow needle in comparative safety. Furuncles in other parts of the body should be treated with hot moist applications or softening applications, as flaxseed poultices or poultices of the various ointments, until fluctuation has appeared and I think they should be incised. One must always keep in mind that the treatment of boils and carbuncles has but two objectives; to destroy the infecting organism, and to augment the protective forces of nature which, after all, are the fundamental principles of sound surgery.

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DISCUSSION

Dr. Horace A. Day, Orlando:

Dr. Chappell has given you a very full resumé of the treatment of boils and carbuncles as has been outlined by many authors.

The fact that impressed me the most was that all boils, carbuncles and furuncles have to be treated differently according to their anatomical location, the extensiveness of the infection, the

resistance of the patient and the pathological condition of the part involved.

Now, under conservative treatment, we have first the general care of the patient. We must take into consideration, as he brought out, whether the patient has any other associate disease such as diabetes. Then, we have many types of foreign proteins and other vaccine treatments which tend to increase the number of leukocytes which surround and wall off the infection. Then, the most marvelous thing in the prevention of all these boils is sunshine, the ultraviolet rays of the sunshine which produce the tan to cover our skin and keep them out. If you tell your patient to take a sunbath and get tanned he will not be bothered with these sores and carbuncles.

As Dr. Chappell stated, treatment should be based on the position of the boils, taking into consideration the anatomical parts. The best thing, I think, in conservative treatment is heat. Heat increases the blood supply and tends to have nature wall off the infection so that it does not spread. As long as the infection is not spreading you can continue conservative treatment until fluctuation takes place.

Don't incise unless the infection is spreading. You can notice in the fat parts of the body a tendency to extend down deep into the fascia. By feeling around, you can tell how much spreading it is going to do. As soon as you get fluctuation, it is fairly safe to incise it. However, as Dr. Chappell brought out, when the face is involved it is a dangerous procedure.

Dr. J. Ralston Wells, Daytona Beach:

I think Dr. Chappell is to be congratulated for so thoroughly covering the field of the very common infections, as boils and carbuncles. Because they appear simple we all think we know all about them but when we sum up our knowledge we don't know so much about these infections after all.

I agree with Dr. Chappell that conservative treatment in boils is very much to be desired, particularly around the face. And as Dr. Day said, the face is a particular anatomical part of the body that should be treated much differently from any other part. The upper lip or upper parts of the face of course are considered the most dangerous. But personally I have found the lower lip and jaw almost as dangerous from a designated infection. I have had several cases of streptococcic pneumonia in the upper right lobe of the lung following such an infection. I think anything around the face should be treated with extreme cautiousness.

I have nothing new to bring out that Dr. Chappell did not mention. But I would like to emphasize what he said about conservative treatment, moist heat, etc. He also mentioned vaccines from foreign proteins. I would like to mention in this connection that any vaccine to be of value should be autogenous. However, it takes 36 to 48 hours to procure this vaccine, and foreign protein is ready immediately. In my experience I have found that the most success will come from using a combination of the two. Give autogenous vaccine at the first opportunity, and repeat progressively larger doses on third, fourth or fifth day, according to reaction but give foreign protein every day in full doses. All of these foreign proteins that Dr. Chappell mentioned seem to me to give the desired result with or without febrile reaction. A great many of these cases develop very quickly and that causes the fever to rise to a considerable degree. You have a very seriously ill patient. Therefore give foreign protein as much as possible. I don't think that a full dose every 12 hours is too much in a serious case for the first few days. These furuncles do get extremely serious. Bear in mind that too much vaccine therapy is dangerous. It must be used as any other therapy.

Following fluctuation of a boil in any part of the body, we all agree that it should be opened. But, again I think the opening of these areas even after they do fluctuate, should be with extreme care. When nature is attempting to wall off a furuncle, I think you will accomplish your purpose without any spreading if a small puncture wound is made and then spread open with a hemostat.

The idea of putting foreign blood or autogenous blood in and around the area I think is dangerous in that it might get into the tissue which is involved and help to spread a limiting process. The lymphocytes are doing their best to wall off the infection and if you disturb them and carry the infection on through you have done little good and a potential harm.

When a furuncle is incised it should be done with the smallest possible opening. Electrocoagulation, as Dr. Chappell mentioned, is a very safe and sane procedure, and can be done easily without pain and without anesthetic. A small

opening is made and the end of the cautery is introduced to burn the fibrous and necrotic stroma. In a carbuncle a larger or crucial opening is made or possibly a dissection of all readily accessible necrotic tissue.

I think Dr. Chappell is to be congratulated for putting a subject such as this into concrete form so that we may all realize it and discuss it with intelligence.

Dr. W. Duncan Owens, Miami Beach:

Dr. Chappell has covered this subject so completely that he has left very little to be said. However, I want to mention a series of cases that I have recently had; Dr. Payton, radiologist, collaborating. I agree with Dr. Chappell and Dr. Day as to anatomical treatment, but these cases were treated by x-ray irrespective of their location. One was on buttocks, one over sternum, one on back of neck, one over angle of scapula, two over patellar ligament, one on side of neck, one on lower jaw—a total of eight cases, all clinical carbuncles. All were given x-ray radiation, 80 kv., 150 to 250 r. of unfiltered radiation at a distance of 40 cm. Hot packs of saturated solution of magnesium sulphate were then applied continuously and fluids forced. Liquefaction occurred almost regularly within two day's time. It was not necessary in any instance to incise, the top lifting off easily with forceps and they readily drained themselves. The longest course of any one was eight days to discharge.

Dr. Payton considers that the effect of x-ray radiation therapy in boils and carbuncles is a rapid and well-defined localization of the infection with accelerated central necrosis and liquefaction.

Dr. A. K. Wilson, Jacksonville:

I feel that this subject is of special interest to rhinologists and otologists. We have a good many of these cases and are taught that the danger of infection of the face is due to the fact that most of these veins have no valves so the infection very readily travels up these veins to the cranial cavity and to the general circulation. I would like to speak on the prophylactic part of this subject. We feel that furuncles in the nose are due to traumatism. Most of these cases are patients who are allergic or have some sinus infection, and the nose inside oftentimes is covered with crusts or watery secretion, and the patient in trying to remove this injures the skin. My experience is that most of these cases of furuncle in the nose are people with very large nares, able to introduce the finger and oftentimes a handkerchief wrapped around the finger. Cleaning the nose out in this way produces dryness and excoriated skin, thereby allowing the infection to get around the hair follicles and abraded surfaces. Having these patients apply plain vaseline or 3% ammoniated mercury in the nose once or twice a week will help in preventing infection. Ointments with petroleum bases will stay on the parts much longer than animal or vegetable oils. We should instruct our patients not to pull hairs out of the nose but clip them. Furuncles in the ears are also due to traumatism; most of these patients have a chronic eczema or seborrhea of the ears. They habitually introduce matches or tooth picks into the ear to relieve itching and to remove debris which are seen with chronic seborrhea. These cases are also brought on by dryness and traumatism from excessive cleaning. Peroxide should not be used in ears with furunculosis as most of these infections are of the aerobic type of pyogenic bacteria.

Dr. J. R. Chappell, Orlando (concluding):

When I was asked to read this paper I made up my mind that I would not enter into any discussion referring to early sinus thrombosis, but it is practically impossible to write a paper on furunculosis without going into that subject. Most physicians, when the word furuncle or carbuncle is mentioned, immediately think of sinus thrombosis. I believe most of you have seen some patient die from sinus thrombosis due to an upper facial infection—a horrible thing.

The subject of boils and carbuncles was completely reviewed by Frederick Christopher of Chicago in the Journal of Surgery, Gynecology and Obstetrics in 1928. Up to that time he reviewed the literature completely and in closing his paper he made the statement that nothing had offered very much success in the treatment of boils and carbuncles during the past twenty years. Since that time we have not had anything to add at all, with possibly one exception, and that is the use of insulin. I am firmly convinced that all boils that occur in a series or crop are due to some disturbance of the sugar metabolism of the body. Most of these patients who are suffering from that trouble can trace the beginning of the boils back to a large carbohydrate meal and even when the blood sugar

is within normal limits. They can all tell you, or the majority of them can, that these boils followed within twenty-four hours the ingestion of a large carbohydrate meal.

I firmly believe that insulin in small doses, not more than two or three units, daily, will break up almost any group of boils or carbuncles that occur in a series. Of course, if not seen until later on it is necessary to incise them.

I would like to thank the gentlemen for their discussions.

PRESENT MEDICAL TRENDS*

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Pensacola.

During the past several years there has been a drastic revolution in the structure of social relationship. The depression has produced innumerable forces that seek to change the existing order of things. There is no business or profession that has escaped the effects of this revolution. As medical men our outstanding economic problem of today is that of Compulsory Health Insurance or State Medicine, which is apparently under serious consideration by the Federal Administration. President Roosevelt, in referring to health insurance at the National Conference on Economic Security, November 14, 1934, said: "Whether we come to this form of insurance sooner or later, I am confident that we can devise a system which will enhance and not hinder the remarkable progress which has been made and is being made in the practice of the professions of medicine and surgery in the United States." Following this Conference the President appointed a Committee on Economic Security and they in turn created four Advisory Boards: 1. Medical; 2. Dental; 3. Hospital, and 4. Public Health, to give technical and other advice in the study of this problem.

All four Advisory Boards have joined in recommendations for the extension of public health activities for the prevention of disease. But for the consideration of health insurance, the Medical, Dental and Hospital Advisory Boards have asked for further time. Some believe that the report on the study of health insurance is definitely shelved, while others believe that, since the subject of socialized medicine has become so popular it is likely that the study of health insurance and its application to the United States will be continued and possibly concluded during 1936.

The 1935 session of the State Legislature passed what is known as the 1935 Social Welfare Act of Florida. Briefly, this Act provides for the appointment, by the Governor, of a State Board of Social Welfare to consist of seven members, at least three of whom shall be women. The members are to serve without compensation, except the payment of their necessary expenses. This Board is authorized to employ, at a salary not to exceed $4,200 per annum, a secretary to be known as the Commissioner of Social Welfare to administer the provisions of this Act, and such additional personnel as the State Board may require.

The State has been divided into twelve Administrative Districts, each with its District Board of Social Welfare, consisting of representatives from each county in the district on the basis of one representative to each 25,000 of population, or fraction thereof, in each county. The members of the District Boards are also appointed by the Governor and serve without pay, other than an allowance for expenses. These District Boards are also authorized to employ a secretary to be known as a District Director of Social Welfare and such other personnel as may be necessary.

This Board is directed, by the Act, to extend adequate assistance to those who are unable to provide for their own needs. Subject to the jurisdiction of the State or District Board, medical and other care will be provided in hospitals, dispensaries and individual homes.

However, the failure of the State Legislature to make appropriations for the carrying out of this Act will naturally delay its detail operation, unless a grant is made to the State by the Federal Government. The Act terminates July 1, 1937, unless re-enacted by the Legislature.

The medical profession, as those of nearly all vocations, must look with apprehension, if not real alarm, at these Social Security measures as the opening wedge of social organization by regimentation and as a prelude to avowed "communization" of our calling.

Such arbitrary congressional acts as were passed for establishing equality or "parity" in other callings is just as logically conceivable as applied to our own, to our grocer friends or fishermen as to potato or cotton growers.

Thousands in each of these occupations find their earning barely sufficient, or insufficient, to keep the family and automobile going and many feel a sense of resentment that others in like occu-

*Read before the Florida East Coast Medical Association, St. Augustine, Nov. 1, 2, 1935.

pations seem to fare well in this lack of "parity" as it is uninsinuatingly called.

The Florida Medical Association has taken the initiative in calling a general conference with representatives from the State Dental Society, the State Pharmaceutical Association, State Board of Health and the State Board of Social Welfare. As a result of this meeting the Florida Advisory Council for Medical Relief was formed consisting of one representative from each of the above groups.

This Council made formal request on September 26, 1935, to the Honorable Harry L. Hopkins, Administrator, FERA and WPA for a grant to the State of $1.50 per capita per annum to provide medical and dental service in the office and the home and to provide drugs and prosthetic devices to persons in this State, who, by reason of no income or because of inadequate income are unable to provide such necessary services for themselves. It was brought out by the Council that the professions concerned have in years gone by, unselfishly and from their own resources, met these responsibilities except during that period when FERA shared part of this responsibility. Rendering services of this type should not be borne alone by the doctors, dentists, and druggists, but should be a joint obligation between the professions and society. The Government refused to grant the funds requested above.

The doctor of sixty years ago depended largely on his five senses in making a diagnosis, while the doctor of today has every one of his five senses and in addition employs hundreds of new instruments of precision and materials. The report of the Committee on Costs of Medical Care states, "Fewer than ten per cent of the population are cared for in hospitals in any one year. Hospitalized illnesses are so expensive that they consume fifty per cent of the total annual expenditures for all medical care." Dr. Morris Fishbein states that a commission on medical education, after seven years of study, came to the conclusion that about eighty-five or ninety per cent of the diseases for which people consult doctors can be competently diagnosed and treated by a general practitioner with the equipment carried in his handbag or available in his office. The remaining ten or fifteen per cent represent serious disease which require study and treatment in a hospital. Therefore, it is not the usual run of illnesses that financially tax the middle class beyond its income. When hospitalization becomes necessary, room charges, laboratory, x-ray, and nursing fees begin to mount, and the cost of sickness abruptly soars. This fact is worth serious consideration.

The professional social worker speaks of basic relief as food and shelter. They do not agree that medical relief is also basic, even though admitting that it is desirable and sometimes essential. These leaders in proposing new systems of medical care, have not inquired into the wishes of the individual who would be forced to pay for the system and receive the services provided.

If the demands for socialized medicine are to be resisted the allied medical professions must lead the way in calling attention to its defects.

This economic problem has been adopted as one of the major objectives of the Florida Medical Association this year. The welfare of your State Association depends upon the support you give it. United action is absolutely essential. Your State Economic Committee with the approval of the Executive Committee has submitted an agreement to the State and Federal authorities, which accompanied a request for the funds referred to above, embodying the following basic principles: 1. The preservation of the personal relationship between the doctor and patient, to assure medical services by individual physicians of his choice. 2. Organized medicine to have an administrative voice in any plan eventually adopted. 3. A uniform State-wide procedure in the provision for medical care. 4. The distribution of funds to be made on the basis of population by counties. 5. The medical needs of individuals whose incomes are sufficient to remove them from the indigent class, yet insufficient to permit the payment of prevailing medical fees, to be provided through a reduction in prevailing fees commensurate to their income.

It is the desire of organized medicine in this State to cooperate with city, county, state and federal agencies in dealing with health problems, but it must be understood that professional services cannot be dispensed like merchandise.

We are, perhaps, more than any other group of citizens called upon to sympathize with and hear the complaints of humanity during these days, weeks, months and years of depression. How often do we listen to the echoes of social theories as enunciated by the true or erroneous interpretation of social needs and their remedies by New-Dealers.

As doctors of medicine, familiar with the

panaceas of quackery, we might wonder if the alphabetical method of designating multifarious social remedies derived its origin from such medical prototypes as XYZ, etc.

When we hear and read the high sounding and mellifluous pronouncements of these social doctors we think of the question and the answer in old rhyme, *

What is a Communist?
One who hath yearnings,
For equal division and unequal earnings,
A trifler, a bungler,
Say thing—he's willing
To fork out his penny and pocket your shilling.

From such social philosophy, as men of intelligence, we are called upon to protect ourselves and our institutions by the exercise of economic and political common sense.

MANAGEMENT OF ACUTE GONORRHEAL INFECTIONS*

Personal Impressions Acquired From Fifteen Years' Experience.

Roy J. Holmes, M.D.,
and
Milton M. Coplan, M.D.,
Miami.

A large proportion of male gonorrheal patients may be assigned roughly to two main classifications: First, there is the optimistic individual, who comes to our office after two or three weeks' treatment and when questioned answers with a broad grin on his face, "Sure, I'm getting along fine. Only noticed a small drop this morning. nothing at all during the day. Pain? No, I haven't had any pain. Sleep like a top and never felt better in my life. Wouldn't know I had gonorrhea as far as my feelings are concerned."

Then there is the other fellow, the fellow who throws the entire office force into a sort of melancholic dilemma when we see him limping slowly down the hall. In his opinion his is the fate of the damned. He has mentally consigned himself to social ostracism and eternal oblivion. Watch him as he slowly unwraps with trembling fingers a red, pus soaked part of his anatomy, which seems to have gone the way of all flesh. He is a connoisseur in the study of the voided specimen of his own urine. He asks questions that would break the heart of an angel and is disappointed if your reply is anything short of what might be expected in the darkest recesses of an undertaker's establishment. Listen to his tale of woe day after day and then ask yourself why in the light of our present knowledge should there be such a difference in the reactions of different patients to the same disease; a disease that would remain local and give very little discomfort in the majority of instances even if no treatment whatsoever were instituted.

In this connection we give full cognizance of the personal equation. We also recognize the questions of individual resistance, together with the theory that a particular strain of gonococci may be more virulent than other strains. Our conclusion, however, is that the answer lies principally in the manner in which the disease has been managed from the onset by the patient as well as the physician.

Here, as perhaps in no other disease, attention to the smallest detail often determines whether or not our patient will respond promptly and happily or suffer mentally and physically far beyond what might ordinarily be expected. For example, absorbent cotton may absorb water but it will not absorb gonorrheal pus at the meatus. It will obstruct drainage from the urethra and stick to the meatus so firmly that often it can only be removed with pain and difficulty. A string or rubber band around the penis, a jockey strap, or a pair of the new jockey drawers will almost invariably interfere with free urethral drainage and lead to posterior urethritis with other complications likely to occur.

A consideration of these points, not to be found in standard textbooks, will probably not be amiss at this time. In the first place, if you, the physician, are not interested in gonorrhea; if you look upon it simply as a dirty, filthy disease, and with but little sympathy for the patient; if you would rather take a beating than massage a prostate gland or handle with your hands the offending part during one of its most pathetic moods; then it is far better for you not to attempt to treat gonorrhea at all. "But," you say, "I have to treat it. There is no one in our community who is better prepared or is the slightest bit interested in gonorrhea." Our answer is that we believe it to be better for the patient to ride fifty or seventy-five miles once a week for observation, considerate advice, and proper instructions regarding self-treatment than it is for him to visit daily the office of one whose preparation and temperament do not correspond to his needs.

The first and best advice that we give to every

*Read before the Florida East Coast Medical Association, St. Augustine, Nov. 1, 2, 1935.

male gonorrheal patient who is married is to go home immediately and tell his wife about it. Just *how* he tells her is no particular concern of ours. "But, Doctor, you don't know my wife," he says. Perhaps not, but we do know something about gonorrhea. We insist that she deserves consideration and protection from an infection that may disable her for life. Women have a happy faculty of fooling themselves. They seem to be able to make themselves believe just what they want to believe. Some of them even love their husbands well enough to let him get away with the old toilet seat story. Others can very easily attribute his misfortune to the quality of the liquor which he was drinking at the time. Almost without exception they appreciate a frank confession and are willing to cooperate to the fullest extent if the husband shows the proper consideration for her and sincerely regrets his moment of weakness.

In the past fifteen years we have never had occasion to regret having given this advice. In the same period of time we have seen three suicides, a great deal of divorce and unhappiness, and one murder case in which this question played an important part. When we consider, furthermore, the number of wives who have contracted infection from husbands who wouldn't face the music, we are positive that the doctor has more than one responsibility where gonorrhea is concerned. Quite often a good heart-to-heart talk between the doctor and the patient's wife, but always with the patient's consent, will soothe the troubled waters and make everyone involved a bit kinder and more sympathetic with the frailties of human nature. It is worth while sending a couple, who came in at daggers' points, away from your office hand in hand, cheerful, and in a happy mood in spite of what they considered an irreparable calamity.

In examining the gonorrheal suspect it should be obvious as well as important that one of the first considerations is to look at the penis. As elementary as this may seem it is surprising the number of things one may learn from simple observation. Study the meatus in a good natural light. Is it red, inflamed and pouting, or does the mucosa just within the meatus appear perfectly natural and healthy? Regardless of the microscopic picture this observation will frequently be the clue in differentiating between a fresh infection and the return of an old uncured infection. Is the discharge cheesy and sticky when touched with a wooden applicator, or does it give the appearance of being one hundred per cent pus? If the former is the case, always suspect the prostate gland as headquarters for the infection. If the meatus presents signs of inflammation, and if the pus discharge is apparently unmixed with prostatic fluid, the chances are that we are dealing with an acute anterior urethritis of recent origin. The microscopic picture is often the same in both instances, both intra and extracellular organisms being found. One of the most annoying fallacies which seems to be quite prevalent among those who treat gonorrhea is the idea that if the second glass of urine is clear, the prostate gland cannot be involved. We not only wish to condemn this method of reasoning as unsound, but we go further and say that the second glass of urine gives us no information whatever regarding the condition of the prostate gland. It frequently tells us to what extent the infection has extended into the posterior urethra but we insist that a patient may have an acute prostatitis or a prostatic abscess as large as a lemon and yet have a perfectly clear second glass of urine. We always investigate the prostate gland by rectal examination and by studying the prostatic fluid at about the third or fourth week of the infection regardless of how uneventful or ideal the course of the disease has been.

Another word regarding the two or three glass test: When a patient brings the glasses of urine across the room to us or holds them proudly or otherwise before the window in anticipation of our explanations or comments, we immediately begin talking about the baseball game or the stock market. This phase of our technique is treated very lightly in the presence of the patient, having learned from experience that if we go into details regarding the meaning of the two-glass test or every little thread which appears therein, the chances are that we will have either a neurastheniac on our hands, or an individual who will be looking anxiously at his urine every morning for the rest of his life.

We also believe that it is a mistake to show the patient the gonococci under the microscope or to go too graphically with him into the "wheres and whyfores" of the disease. If the physician is extremely talkative about every phase of the disease he must be prepared to spend much of his time explaining today why he said what he said yesterday. When two physicians are working together, both treating the same patient, too much explaining or idle talk is a distinct disad-

vantage as it is very easy for their opinions to disagree, thereby leading to confusion on the part of the patient, and a firm conviction that neither of them knows what he is talking about.

We dwell upon these points because it has been our experience that the gonorrheal patient is extremely pessimistic, worried, anxious about his disease, and an excellent candidate for one of the sexual neuroses. Since the dawn of time the first law of nature has been, not self-preservation, but the perpetuation of the species. It is to be expected that a disease which involves both of these laws so intimately should instinctively provoke more anxiety and mental unrest than almost any other disease, which does not threaten the life of the individual.

The back-slapping, dirty-joke-telling type of venereal specialist is rapidly giving ground to the calm, reserved but friendly, urologist of today. The latter answers all intelligent questions respectfully. He prefers to direct his time while with the patient in lending encouragement, sympathetic understanding, and straightening out any kinks of confusion which may arise in the patient's mind. He is the patient's counselor and friend, yet he does not go to the boxing match with his patient upon the slightest provocation. His dignity is a thing so subtle as to command respect and admiration. He is never unapproachable.

Now, back to the meatus. As free drainage is one of the prime requisites for successful treatment it is always advisable to know the exact caliber of the meatus. Just within the meatus lies the fossa navicularis, the internal boundary of which corresponds roughly to the size of the meatus proper. The fossa navicularis is, so to speak, simply a wide place in the road. In performing a meatotomy, therefore, we not only open the road leading from the fossa navicularis but attention must also be given to the inlet which is situated from one-half to one-quarter of an inch within the meatus. Both of these areas of constriction must be opened thoroughly or else one has not gained the object of this minor operation.

There is only one way to obtain accurate information regarding the true caliber of the urethra and that is by skillful use of the acorn tip boule of graduated sizes. There may be men who can feel strictures with a steel sound simply because of a sensation of tightness which they get when passing the sound, but, frankly, we have never reached this degree of perfection, and have found that many normal urethrae are plenty tight even when an average size sound is passed. Our rule is to advise meatotomy in all cases in which a size 20 acorn tip boule will not pass freely down the urethra for a distance of one inch below the meatus. We are not satisfied with our meatotomy unless we can pass a size 28 or 30 boule the same distance after the operation. Following the operation the first inch of the urethra must be dilated every day for five or six days.

Urethral sounds were originally invented for the purpose of dilating strictures of the urethra. They are used now not only for diagnostic purposes but often simply because we happen to be in a bad humor or can think of nothing else to do for the moment, which will be half as impressive. Is it any wonder that a great many men prefer to take their chances with a toilet room prescription after listening to their friends speak of the horrors of instrumentation? The good surgeon tries to avoid operations. The good urologist uses the sound only when there is a definite indication. Passing sounds in order to provoke a discharge when the disease is questionably cured has always appeared to us as a procedure of doubtful value.

What constitutes good treatment in these cases? First of all we must recognize the fact that we possess no specific for gonorrhea; that the disease to a remarkable degree, is self-limiting; that the infection cannot be overwhelmed with antiseptics; and that gentleness, cleanliness, and good drainage are the keys to successful treatment. We have at our disposal an antiseptic (acriflavine), which will kill the gonococcus instantly in dilutions of 1 to 20,000 or even less. We can use this antiseptic in the acutely inflamed urethra in dilutions of 1 to 4,000. Our results, with few exceptions, have not been any better with this powerful antiseptic than with mild potassium permanganate irrigations which have little or no antiseptic value whatsoever. We all recognize this fact and yet we continue to prescribe mercurochrome, some of the silver and iodine solutions, and other extremely irritating drugs to be given by the patient behind the barn door five or six times daily. Even the normal urethra will not tolerate this abuse.

Gonorrhea, as we regard it, can be compared with erysipelas. Within thirty-six hours the gonococci have penetrated the mucosa and cannot possibly be reached by antiseptics. We all know

the futility of trying to check the spread of erysipelas by painting the surface with tincture of iodine. Gonorrhea differs only in that it spreads by extension on the surface as well as by penetration. Antiseptics *will* destroy organisms that are spreading by surface extension, but the value of local treatment is not so much bactericidal as it is in stimulation of the natural forces of the mucosa and deeper tissues. The mildest type of antiseptic will do this and it is this, and this alone, that we can hope to accomplish without injury to the underlying tissues. The very moment the tissue is injured by powerful and irritating antiseptics or by using a mild antiseptic too often, we have aided in defeating the object of our treatment. We are convinced that one or two mild treatments daily is much better than four or five; that the use of a preparation of slight antiseptic value is preferable to a powerful germicide, which is capable of producing urethral irritation. If the general practitioner, who is usually the one who first sees these patients, will realize that oftentimes it is better not to do quite enough than it is to do too much, we feel quite sure that he will feel a great deal more confidence and will obtain much better results in the treatment of this disease.

It may be of interest to summarize briefly and rather roughly our experiences with various antiseptics. They are as follows: Acriflavine, the most powerful gonococcide in general use is very deceptive. In proper dilutions it is apparently not irritating and will occasionally abort gonorrhea or arrest the disease within a very short time. Many patients, however, will not tolerate it. The urethra begins to itch, burns, and becomes irritated about the fifth or sixth day. If its use is continued when these symptoms become evident strictures and induration of the urethra will inevitably follow. It should be given a trial in selected cases which can be watched very closely. Argyrol and silvol are dirty and of little germicidal value. If used too often they become irritating and cloud the urine so that one can get but little information from the two or three glass test. Mild, warm potassium permanganate irrigations are excellent. They cleanse the tissues by their flushing and oxydizing effect and stimulate the natural forces of resistance of the mucosa and deeper tissues. Mild solutions have little if any germicidal value yet this is the most popular treatment and has stood the test of time. Our objection to any irrigation treatment except in the most expert hands is that too many complications such as acute prostatitis and epididymitis are likely to occur. Neo silvol is of little germicidal value and does not seem to irritate the mucous membrane even when used several times daily. It is excellent in cases where self-treatment is necessary. Mercurochrome should never be used in acute gonorrhea. We doubt if it has any place whatever in the treatment of this disease. Protargol, nargol, and other silver neucleides are of some value but very likely to become irritating to the mucosa.

We all have our pet remedies or prescriptions which we swear by. Ours is and has been for the past four years, a solution of rivanol dextrose. Rivanol was introduced as an antiseptic by Morgenroth in 1920. It is an acridine preparation and, in our hands, seems to fulfill all the requirements of an antiseptic and does not injure the tissues. On the other hand, it seems to exert on them a stimulating effect which puts them in the best possible condition for defensive action. We dissolve the contents of one capsule, which contains 1½ grains of rivanol, in 3½ ounces of distilled water. The solution is made fresh every day. In cases of anterior urethritis three or four drams of this solution are slowly and carefully injected into the anterior urethra once daily in our office and retained in the urethra for five minutes. We never give or allow the patient to give himself more than two injections daily. One must be thoroughly familiar with the technique of giving an anterior injection; must never use force; and must stop the injection just at the point when the anterior urethra gives the sensation to the palpating fingers of being filled or slightly distended. We never allow self-treatment except in the most urgent cases of necessity. Whatever self-treatment is allowed should be carried out only after the most minute and painstaking instruction in every detail has been given.

Following treatment our dressing consists either of the well-known butterfly dressing or the combination sanitary bag and suspensory with the necessary amount of gauze in the bag, which can be changed at frequent intervals. Our instructions are few and very simple. We insist upon cleanliness, good drainage and good behavior. No alcohol and no sexual excitement are our only essential conditions of conduct. We pay very little attention to diet or internal medication except for special conditions. We do encourage the patient to drink large quantities of water, preferably a glass every half hour.

We do not believe that we have ever obtained any beneficial effect from the use of any of the so-called urinary antiseptics given internally. We have given gonorrheal filtrate and vaccines a fair trial in several hundred different cases and have abandoned them entirely. Our treatment is very simple, very conservative, and dependent to a large extent upon gentleness and a very high regard for the urethral canal.

Along about the fourth week of treatment the patient is usually greatly concerned about whether or not his urine or smear continues to show the presence of gonococci. We are perhaps unorthodox in saying that we pay very little attention to the presence of gonococci at this stage of the disease. In fact, we do not even waste our time looking for the organism. We are much more concerned with obtaining perfectly clear first and second glasses of urine upon examination of centrifuged specimens. We tell the patient that we are treating pus and not the gonococci, and in reality this is exactly what we are doing. One can look for gonococci and not find it day after day, but if the centrifuged urine continues to show the presence of more than a few pus cells to the field, one is never safe in pronouncing the patient cured. The same applies to the expressed fluid from the prostate gland. We believe that since adopting this idea of treating pus cells instead of gonococci we have eliminated the provocative measures, which are so often used, and that by doing so we see comparatively few recurrences. We admit that this takes more time but we have learned that it pays to restore the urine and prostate gland to normal even if it takes us from four to six months to do so.

We are aware that in this short discussion we have given you nothing new. There is nothing new about the doctrine of seeing cases of pulmonary tuberculosis early and giving them plenty of rest in bed over long periods of time. This doctrine was preached for years while our profession still insisted that there was some peculiar magic in a North Carolina mountain top. It was only when we, as a whole, grasped the significance of this elementary idea that we succeeded in reducing the tubercular rate from first to sixth place among the causes of death.

We know of not one single authority anywhere who is not preaching the doctrine of gentleness and conservatism in the treatment of gonorrhea. Gonorrhea, we repeat, cannot be overwhelmed with germicides or antiseptic solutions. When we fully realize this point and accept it as something more than idle "chin music", then, and only then, will we cease to hear the oft-repeated comment that, "We have not made any progress in the treatment of this disease in the past fifty years."

Our message is one of extreme optimism. We are not advocating a "do nothing" policy by any manner of means. Nature and the natural forces of resistance need our help just as much as we need theirs, but we must be respectful about it. No doctor ever succeeded in curing a case of gonorrhea without the help of these valuable companions. It is only since they were admitted into our partnership that the treatment of gonorrhea has become a pleasure rather than a nightmare, that we have become possessed with a consciousness of a job well done rather than a consciousness of having laid some poor devil up for a week or a month with epididymitis or gonorrheal rheumatism. Of course we have our complications, too many of them in fact. Our results are probably no better than those of hundreds of other men, who have become converted to the conservative ideas herein expressed, but taking it all in all, and in spite of the fact that we see quite a number of cases of gonorrhea every day, we are happy, we sleep very well at night, our blood pressure is low, and our conscience is troubled with everything in the world except gonorrhea.

HOARSENESS*

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Impairment of the normal phonatory function of the larynx may result in huskiness or hoarseness. This is not a clinical entity, it is only a symptom.

The organ of voice is in a membrano-cartilaginous box-like structure known as the larynx; it is situated below the epiglottis and extends to and is continuous with the trachea. On looking in from above, one sees two pink ventricular bands which are the false cords, the ventricular space below, and two white dense elastic fibrous bands extending back from the thyroid to the arytenoids, known as the true vocal cords.

The air from the lungs is forced against the vocal cords which sets them vibrating, producing phonation. The cords are brought together by the adductors under the force of the will, and

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are separated in respiration by the abductors.

Sensation to the larynx is supplied by the superior laryngeal branch of the vagus. The recurrent laryngeal nerve supplies motion.

Hoarseness or aphonia may be acute, chronic, or intermittent.

The sudden occurrence of hoarseness frequently calls for immediate examination of the larynx, and prompt diagnosis is ofttimes necessary in order to prevent death. I refer to such conditions as laryngeal diphtheria, foreign bodies, edema, etc. In these conditions, dyspnea, and dysphagia, reflex cough, referred pain to the ears, and wheeze are always present.

A diagnosis of hoarseness is made from the sound of the voice. The determination of the lesion producing the hoarseness is of the utmost importance and one should not be satisfied with a superficial examination, because frequently two or more lesions coexist in the same patient. It goes without saying that an inferential diagnosis is as unsatisfactory as it is unscientific. It is my practice to follow a systematic plan of laryngeal examination which includes history, indirect and frequently direct laryngoscopy, examination of the adnexa and blood; roentgen and bacteriologic studies; and occasionally esophogoscopy, bronchoscopy, and biopsy.

We should make repeated painstaking examinations when the diagnosis is uncertain and should never be satisfied with a casual examination only to send the patient away with a false sense of security.

In children, papilloma of the larynx is the most common cause of hoarseness, in early adult life tuberculosis, and in late life, cancer. The latter may be mistaken for tuberculosis, syphilis, benign tumors or chronic infiltrative laryngitis.

The appearance of certain lesions is often typical so that a provisional diagnosis can be made, but a positive Wassermann should be expected in a patient whose larynx is typically luetic, and we should expect pulmonary tuberculosis where tuberculosis of the larynx is present.

The laryngologist frequently is the first person to suggest an aortic aneurysm, or mediastinal changes on observing an incipient adductor paresis.

Patients are often advised to have a deviated septum corrected or pathologic tonsils enucleated to cure hoarseness. This is unscientific advice. These may be present and their correction may help the patient, but other pathology will be found if looked for. Nasal obstruction may produce voice changes, but this is not true hoarseness.

It has been said that any person over forty with constant hoarseness for at least six weeks should be suspected of having laryngeal carcinoma. Malignancy seems to have a predilection for the anterior portion of the cords, but this is not pathognomonic. There is a constant desire to clear this part of the throat and an annoying laryngeal cough present. Dysphagia is present when the esophageal region is involved, or if the epiglottis is involved. Fixation of the arytenoids is present, but inflammatory infiltration may produce it in other pathologic processes. Although the lymph glands may be involved, this may not occur in intrinsic carcinoma, so our positive diagnosis is, in the final analysis, dependent on the pathologist's report of the biopsy.

Tuberculosis of the larynx nearly always begins in the interarytenoid region. The usual picture is a pale mucous membrane, and "rat-bitten" ulceration of the vocal cords, in a person with a pulmonary tuberculosis. Primary laryngeal tuberculosis is most uncommon, and many clinicians deny its existence.

Syphilis manifests a preference for parts other than the cords; it is frequently diagnosed as chronic laryngitis in which other symptoms may not be seen. A deep infection of the entire larynx and infiltration in the cords and subglottic region, is the most common finding in cases without gummatous formations. Breaking down of the gumma, which becomes secondarily infected, forms one of the most destructive lesions seen. A biopsy will reveal chronic inflammations with specific vascular changes.

A vocal cord neoplasm might prevent cord approximation, and hoarseness will be the result and continue unless muscular hypertrophy ensues to compensate for the impairment. Vocal nodules, pachydermia laryngis, screamers nodes, and fibrous polyps are the most common of these benign lesions.

Hysterical laryngeal paralysis or functional dysphonia is often difficult to recognize; it might simulate adductor paresis or phonasthenia. In cases of mediastinal lesions or other distant pathology affecting the recurrent laryngeal nerve and producing intermittent hoarseness, one's skill in diagnosis is often taxed to the utmost. Inasmuch as galvanism and faradism are the most helpful remedies in each, the diagnosis may for a while be difficult and delayed.

In a recent survey of several hundred cases of the recurrent laryngeal nerve paralysis, it was brought out that it occurs twice as often in females as males, and that goitre is one of the most frequent causal factors.

There are many conditions in which hoarseness plays a minor part, but it is important and it should not be dismissed lightly because patients are more prone to stress body lesions producing pain. Many physicians do not differentiate between voice changes resulting from nasal pathology and true hoarseness produced in the larynx.

Early and careful examination of all patients who are hoarse will reveal many unsuspected cases of incipient laryngeal carcinoma that will respond to proper care, and in turn will prolong the comfort, voice, and life of some of those destined to an untimely death. It is our duty as physicians and advisors to thoroughly investigate these cases and when necessary have consultations if we want to aid in the reduction of cancer mortality. An incipient carcinoma is relatively responsive to treatment, an extrinsic cancer practically hopeless.

REPAIRS OF LACERATIONS OR WOUNDS*

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The title of this paper, in the true sense the name implies, covers a very large field of surgery. In the short space of time allotted here, it will be my purpose to bring out only a few of the salient points connected with this type of work and to discuss the subject very briefly. For purposes of discussion, we may divide wounds into two types, namely, closed and open. The closed wounds we may define as those which do not have a break in either the skin or mucous membrane. Under this type we may list contusions, sprains, strains, dislocations, simple fractures and lacerations of any of the internal organs. Of the open type of wounds, we may have incised wounds, wounds caused by chemicals or thermal agents and lacerated wounds. Under the heading of the latter, there are many varieties, namely, abrasions, brush burns, puncture wounds, penetrating wounds, contused wounds, avulsions, wounds of the joints, compound fractures and bites.

In this paper I will deal chiefly with lacerated and incised wounds and their repair and healing. Fortunately, today we obtain much better results than in yesteryears with the wounds we make ourselves, due to our better knowledge of asepsis. Of the wounds we make in our operative procedures today, I do not recall in a number of years of having a so-called stitch abscess or an infected wound. Of the accidental lacerations, the results are not as good but many of these escape infection due to antiseptics used today.

In the healing of wounds or lacerations there are several salient factors to be considered. Many of these are overlooked by the physician doing general work.

To start the proper union of any laceration, the wound must be thoroughly cleansed of any foreign material first and some antiseptic solution applied freely. I personally have obtained my best results by working wherever possible with constant application of one of the non-irritating antiseptics such as 1-2500 metaphen, 1-2000 merthiolate or mercarbolide. In this way the solution gets to all the parts of the tissues as thoroughly as possible. The torn and uneven edges of the wound are cut even and any tissue that may slough should be removed. In the application of antiseptics, I believe that the too strong antiseptics should be avoided as at times I have noticed that the wounds did not heal as well as if the milder ones were applied. To get good union in any tissue, the accurate approximation of the wound is essential. The best results will be obtained by first stopping all bleeding that may result in even a small hematoma. Even a small one is sufficient to separate the edges of the wound and delay union. The wound should then be repaired by approximating all corresponding tissues—tendon to tendon, muscle to muscle, etc. In patients where there is excess fat, there should be an approximating row of sutures of plain catgut to hold this. If not, there is a tendency to the formation of serum in the wound from the fatty acid formed by degeneration. As to sutures, any absorbable material may be used with equally good results provided it does not remain unabsorbed for too long a period. I prefer small chromic in muscles and plain catgut in other tissues. For practically all accidental wounds a drain should be used for at least twenty-four hours even if it is only a small one. In regard to closing the skin, I believe that either dermal fine or medium, silk or horsehair is to be preferred. The approximation is accurate and the scarring less. With

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the exception of horsehair, these may either be buried or on the surface. For closing the skin of the abdomen, I believe skin clips are the easiest to use.

To be considered also with the healing of wounds, and often neglected, is the general systemic condition of the patient. A patient with a good percentage of hemoglobin will heal better than one with a low content. A well and healthy person is much more apt to heal quickly than a poorly nourished person. At times we may wonder why a laceration does not heal in an apparently healthy person and a serological test for syphilis may clear the mystery.

Any type of infection in any laceration is a hindrance to good union as we know. Some types are more virulent than others. Again some individuals for some unknown reason, so to speak, "just fail to heal." I point out at this time a patient whom I had for thirteen months prior to her death who developed a phagedenic ulcer on the lower abdomen. This patient came to me for prenatal care. She had always been healthy. She had spontaneous delivery with no lacerations. The child was normal and healthy. She developed typhoid three days after delivery from which she suffered for ten weeks after returning home. When she was regaining strength she developed pain and tenderness over lower abdomen which was superficial. This remained for three days and she returned to the hospital. The next morning an abscess ruptured about three inches above the symphysis. Under general anesthesia this abscess was opened, drained and packed with iodoform gauze. The dressings were changed daily but the drainage continued and the wound gradually spread out in all directions, undermining the skin. The wound continued to spread slowly for a period of ten months. During this time practically every known antiseptic was used in the form of ointments, wet dressings and applications of other forms. X-rays and water-cooled violet light were used along with heat and sunlight without any response. At this time foreign proteins were also used as well as tonics of many kinds. Even though the blood was negative for syphilis, six injections of neoarsphenamine were given intravenously without any response. As a last resort, we decided to try maggots. These were applied in the usual manner and no change had been made when the patient died. I believe that we would have attained results from this form of therapy if it could have been used sooner, but this was impossible due to family interference. At the time of death, the wound looked clean for the first time and two areas of epithlization were present. This wound only extended as deep as the rectus sheath and never had any connection with the underlying structures or pelvic organs. This case is mentioned to show that, regardless of treatment, at times we do not get union.

The fundamental principle involved in the operation for correction of lacerations and their consequences, is the repair of the damage done to the structures by laceration, and to the restoration of them to, as nearly as possible, their normal conditions and functions. To accomplish this the involved parts, especially the muscles, must be exposed freely and approximated correctly. This can be accomplished only by suturing the deep as well as the superficial tissues and the fascia sheath. In other words, the corresponding tissues should be approximated from within outward, care being taken to stop all bleeding and preserving nerves wherever possible. A simple blood clot from a small vessel is sufficient to prevent the desired end result because in its formation it separates partially the approximated parts. Again through either carelessness or where it is impossible to preserve the inervation of the part, the involved tissues may fail to unite as they should due to the interference with the nerve supply.

In this paper, I will deal particularly with the female perineum and its repair.

The principles involved in vaginoperineal lacerations and relaxations amount to the restoration of the pelvic sling by the correction of these deformities. These vary from a vaginal mucous membrane tear to a complete tear back through the anus and into the rectum with resulting incontinence of feces.

The anatomical structures involved and whose repair is indicated may be listed as follows: levator ani transverse perineal muscles, pelvic fascia, perineal body and Colles' fascia. The levator ani muscles generally rupture beyond their origin at the descending ramus of the pubis and run downward toward its inferior margin but not extending into the midline. The transverse perineal muscles are generally medially separated and laterally retracted from their sheath towards the ischial tuberosities or they may be separated from the perineal body on one or both sides. The pelvic fascia may have a triangular tear superficial to the levators and

deep transverse muscles. The medially torn perineal body divides the union of the bulbocavernosus and the superficial transverse perineal muscles. Colles' fascia is also torn with these vaginoperineal lacerations.

Varying degrees of rectocele, cystocele and uterine prolapse that exist with vaginoperineal lacerations may be corrected by the successful repair of these. As to the time of repair of these vaginoperineal lacerations, the best time is immediately following the tear, or certainly within the first twenty-four hours following. Some have advocated an intermediate repair anywhere between the second day and up to two weeks following delivery, this being done by curretting the edges of the wound and bringing together the surfaces. This, to my mind, is unnecessary delay and therefore impractical. Then, of course, we have the cases for secondary repair several months post-partum.

As to choice of operation, the principles of all are practically the same and the best are probably those by Emmet and Tait. From these there are many variations and modifications. Now in regard to repair of lacerations immediately following delivery, too much stress cannot be applied for the reason that many in doing obstetrics do not have sufficient knowledge of either the pelvic anatomy or the surgical repair to properly correct these parts. Too often, only the mucous membrane or skin are approximated, leaving the underlying fascia and muscles to remain separated. Again, a mistake often made is the tying of sutures too tightly in these tissues, resulting many times in cutting through and leaving an unhealed wound.

In immediate repair, the tissues should be thoroughly cleansed with some mild antiseptic and rinsed with saline. All the bleeding is then stopped and the deep structures brought together with chromic catgut. A badly traumatized tissue should be cut away, as it will only slough and may become infected. In suturing the superficial structures, there often is a tendency to put the sutures too close to the margins. These should best be placed about one-half inch back to prevent cutting through. At times we have a submucocutaneous rupture without any visible laceration. In these cases an incision should be made and the hematoma removed, as this will prevent proper union of the underlying structures. Then, a similar repair should be instituted.

Of the more serious types of damage done to the female perineum and vagina is the complete type of laceration, namely: vaginoperineo-anorecto laceration. In this type of laceration extreme care cannot be emphasized too much. Its repair should start with the anal ring and rectal wall and be repaired forward. The first layer of chromic sutures should be placed to approximate the rectal wall from the vaginal side, care being taken not to have the sutures pass through to the rectal side, but to include the rectal wall only and not the mucous membrane. These sutures are cut short and buried by the next tier. In this way capillary attraction by these sutures may prevent infection from the rectum of the whole operative field. Next, the anal sphincter is squarely cut and brought together with sutures of chromic catgut, covering the first tier of sutures in the rectal wall and reinforcing them. Next, and very important, the musculocellular sling is brought together by buried chromic sutures. At this time, these parts are easier to approximate than in secondary operations, as they have not retracted yet and are in a partial state of paralyzation. It is by their union that the success of this operation depends, for this is the sustaining power of the pelvic floor. The remaining connective tissue may be easily approximated with either shotted silkworm gut sutures or silver wire. Personally, I prefer the silkworm gut.

In rare instances where episiotomy has to be done, special attention is also called to the importance of suturing the cut muscle before closing the cutaneous tissues.

In perineal work another factor to insure every advantage in allowing the wound to heal is the immobilization of the parts. If the patient's legs are strapped together for the next several days and the parts cleansed with a mild antiseptic seveal times daily, the results will be improved. To see in a practical way the advantage of this, is to place the fingers on your perineum and move slightly. A surprising amount of motion is noted.

In conclusion, I may say that it has been my purpose to bring out the essential factors with this type of work, namely:

1. General systemic—well nourished and poorly.
2. Variations in types of infection.
3. Use of mild antiseptics instead of strong ones.
4. Good approximation of wounds with immobilization.
5. Good aseptic after-care.

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WHAT MAKES A PROFESSION?

If there is such a thing as a profession as a concept distinct from a vocation it must consist in the ideals which its members maintain, the dignity of character which they bring to the performance of their duties, and the austerity of the self-imposed ethical standards. To constitute a true profession there must be ethical traditions so potent as to bring into conformity members whose personal standards of conduct are at a lower level, and to have an elevating and ennobling effect on those members. A profession cannot be created by resolution or become such over night. It requires many years for its development, and they must be years of self-denial, years when success by base means is scorned, years when no results bring honor except those free from the taint of unworthy deeds.

No career presents more strenuous mental effort, more exacting demands upon time, more sacrifice of means, more foregone leisure, than that of the physician who takes his work seriously, and there are few who do not. No class of men renders a greater and more indispensable service to society than those who practice the art of medicine, in all its branches and selected specialties. Upon no group of men falls a heavier burden or a greater responsibility in peace and in war. And none has done more to advance the cause of a true civilization, in which the blessing of a long life and freedom from illness and suffering is made the supreme test of its attainment on the part of an ever-increasing proportion of mankind.

THE PHARMACEUTIC MAZE

Proprietary drugs today are countless, duplications of simple formulae that can be prepared by any competent druggist are innumerable and the bewilderment of the physician is approaching its zenith.

Hardly a week passes without the introduction by one of the wholesale drug manufacturers of a new product or a "rehash" of an old one introduced perhaps a few months previously, or a product almost identical to one of its competitors with a new name. Progress in drugs is not this rapid—some of our oldest drugs are still some of our best drugs.

Were it not for the high calibre and reputation of some of the worst offenders one would be inclined to believe it to be a purely commercial proposition. Under present circumstances it is impossible to believe it purely scientific.

Some attempt at standardization of drugs should be made by the powers that be. It would not be amiss for the Committee on Drugs of the American Medical Association to consider standardization of names before acceptance.

FLORIDA EAST COAST MEDICAL ASSOCIATION MEETING

The annual meeting of the Florida East Coast Medical Association, with its scientific program and banquet, was held in St. Augustine, November 1-2. The scientific papers were most enjoyable and all those attending the meeting seemed to be enthusiastic about the Association and interested in the functions, from all reports.

The Scientific Session was called at 2:00 p. m. Friday, November 1st. Dr. Reuben L. Kahn, Professor of Bacteriology of the University of Michigan, who had been contacted after the program had gone to press, was present as an invited guest. Those present enjoyed having an opportunity to hear this distinguished guest who is internationally known for his contribution to science in producing the serology test of the blood, commonly known as the Kahn test. He is now interested in immunology and gave an address on this subject entitled "Immunology of Fixed Tissue."

The banquet was held at the Monson Hotel Friday at 7:30 p. m. for the benefit of the members and guests. Most of those who were fortunate enough to arrive in time for the banquet enjoyed the social get-together before the banquet. Dr. Reddin Britt, president of the St. Johns County Medical Society, presided over the

meeting and banquet. Dr. Harrison Walker, president of the Florida East Coast Medical Association, delivered a short address, concerning "The Medical Economic Situation and State Medicine." Dr. Herbert Bryans, President of the Florida Medical Association and guest speaker, gave an address, which should interest every member of the Association. It appears in this issue of the Journal. In the absence of Dr. Marshall Taylor, President of the Southern Medical Association, Dr. Edward Jelks, Councilor of the Southern Medical Association, made a few short remarks concerning this organization and stressed that every doctor's aspiration should be to become a member and attend the St. Louis meeting, especially since Florida was honored in having one of its members as President this year. Dr. Robert McIver, Vice-President of the Chattahoochee Valley Medical and Surgical Association, honored the assembly with a few words. Likewise, Dr. Dan C. Elkins, Professor of Surgery of Emory University, guest speaker of the Scientific Session, arrived in time to enjoy the banquet and honor those present with a short interesting address. Dr. Kahn held the audience spellbound with his impromptu remarks at the close of the banquet. Between these remarks and during the course of the banquet, entertainment was furnished by some local talent. Those present seem to especially enjoy the Negro Melodies furnished through the hospitality of the Florida Normal Industrial School.

The morning Scientific Session was called for 9:00 a. m. Saturday, November 2nd. At the end of the session a most interesting paper, "The Treatment of Burns," was presented by the guest speaker, Dr. Dan C. Elkins.

A short business session was held after the Scientific Session and the following officers were elected:

Dr. Harrison Walker, Miami Beach, President, was succeeded by Dr. E. C. Swift, Jacksonville.

Dr. Spencer Folsom, Orlando, 1st Vice-President, was succeeded by Dr. Reddin Britt, St. Augustine.

Dr. E. B. Hardee, Vero Beach, 2nd Vice-President, was succeeded by Dr. F. K. Herpel, West Palm Beach.

Dr. Reddin Britt, St. Augustine, Secretary-Treasurer, was succeeded by Dr. E. B. Hardee, Vero Beach.

The business meeting was hastily adjourned so that the members could attend the Georgia-Florida football game in Jacksonville.

It is hoped that the excellent registration and the enthusiasm in St. Augustine will be manifest in a larger degree by more members of the local Societies attending the next meeting to be held in Ft. Pierce in 1936. The dates will be announced later.

EDUCATIONAL MATERIAL ON CANCER AVAILABLE IN FLORIDA

The following is a revised list of locations in Florida where cancer educational material, such as filmstrips, slides, projectors, etc., has been made available by the American Society for the Control of Cancer, 1250 Sixth Avenue, New York, N. Y. Any of this material may be secured by addressing a letter to the physician whose name appears opposite the item desired:

SLIDES.

Tumors of the Breast (medical)	Dr. J. M. Hoffman Dr. G. R. Holden Dr. W. P. Adamson Dr. Gerard Raap
Tumors of the Uterus (medical)	Dr. J. M. Hoffman Dr. G. R. Holden Dr. W. P. Adamson Dr. Gerard Raap

FILM STRIPS.

Carcinoma of the Breast (medical)	Dr. J. M. Hoffman Dr. G. R. Holden Dr. W. P. Adamson Dr. Gerard Raap
Tumors of the Uterus (medical)	Dr. G. R. Holden Dr. Gerard Raap
Fight Cancer With Knowledge... (For women's clubs, luncheon clubs, and other lay audiences)	Dr. J. M. Hoffman Dr. G. R. Holden Dr. W. P. Adamson Dr. Gerard Raap
Cancer: Its Life History and Practical Measures for Its Control..... (For university students, nurses, etc.)	Dr. G. R. Holden
FILM STRIP PROJECTORS.....	Dr. J. M. Hoffman Dr. G. R. Holden Dr. W. P. Adamson Dr. Gerard Raap
FILM AND PROJECTOR (movie)..... 8-minute Canti film (for medical profession, medical students, nurses, etc.)	Dr. G. R. Holden

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STATE NEWS ITEMS

Dr. Herbert L. Bryans, president of the Florida Medical Association, delivered an address on "Present Medical Trends" at the annual meeting of the Florida Public Health Association, December 2-4. While in Orlando, President Bryans conferred with a number of officers and members of the Florida Medical Association.

* * *

The Twenty-ninth Annual Meeting of the Southern Medical Association was held in St. Louis, November 19-22. The Florida Medical Association was well represented at this meeting, inasmuch as the following members were in attendance:

W. P. Adamson.....Tampa
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J. R. McEachern.....Tampa
Robert B. McIver.....Jacksonville
Kenneth A. Morris.....Jacksonville
Orville N. Nelson.....St. Petersburg
S. R. Norris.....Jacksonville
G. F. Oetjen.....Jacksonville
W. Grady Page.....Orlando
J. H. Pound.....Chattahoochee
Warren Quillian.....Coral Gables
Shaler Richardson.....Jacksonville
J. C. Robertson.....Chattahoochee
C. E. Royce.....Jacksonville
H. Marshall Taylor.....Jacksonville
Joseph W. Taylor.....Tampa
W. C. Thomas.....Gainesville
Ernest W. Veal.....So. Jacksonville
Frederick J. Waas.....Jacksonville

* * *

The Duval County Medical Society is sponsoring a series of educational broadcasts to be given every Monday evening at 8:45 to 9:00 o'clock, over Station WMBR, Jacksonville. These broadcasts are made possible through the courtesy of the management of this station. The committee in charge of the programs consists of Doctors Thomas E. Buckman, chairman; Thomas S. Field, and Louie Limbaugh. The titles of these broadcasts will be announced.

* * *

Dr. Clyde O. Anderson of St. Petersburg and Miss Eileen Masters of Tampa were married on June 20.

Dr. David C. Thompson, who for many years has practiced medicine in Jacksonville, has moved to Azucar, Florida.

* * *

Dr. A. E. Drexel of Palatka and Miss Charlotte Leah Shipps of Wilkes-Barre, Pa., were married at Wilkes-Barre on November 6. Doctor Drexel is president of the Putnam County Medical Society.

* * *

Dr. Duncan McEwan of Orlando and Miss Marion Friess of Brooklyn, N. Y., were married in Brooklyn on October 23, 1935.

* * *

Dr. M. A. Lischkoff of Pensacola was the guest speaker at the October meeting of the Mobile County Medical Society, Mobile. He discussed "Hoarseness."

* * *

Dr. A. E. Drexel of Palatka recently completed a six months' intensive postgraduate course in surgery in New York City.

* * *

Dr. W. W. Bauer, Director of the Bureau of Health and Public Instruction of the American Medical Association, gave an address on "Coordination of Private Practice and Preventive Medicine" at the Orlando meeting of the Florida Public Health Association held December 2, 1935.

* * *

Dr. John W. Hodges, who practiced in Miami in the winter and in Hampton, Virginia, in the summer, died November 27. He was buried in Washington, D. C.

* * *

Dr. Paul Colson Perry of Richmond, Virginia, died on June 5, 1935. Doctor Perry, who for many years practiced in Jacksonville, served as President of the Florida Medical Association in 1913.

* * *

Dr. Edgar S. Estes of St. Augustine, died at his home on December 6. Doctor Estes was chief surgeon at the Flagler Hospital for many years, resigning from that post some months ago.

* * *

Dr. J. Blake White of Daytona Beach and New York died on November 4. He was a member of the Volusia County Medical Society.

* * *

Dr. C. H. Glidden of Ft. Pierce, a member of the St. Lucie-Okeechobee-Indian River-Martin County Medical Society, died November 21.

WILLIAM C. PUMPELLY

William Collins Pumpelly was born in Candor, New York, June 16, 1877, and died in a West Palm Beach hospital, September 18, 1935. He is survived by his wife, Mrs. Anne Singleton Pumpelly, by a daughter, Mrs. Mary Adelaid Head, who resides in Canada, and by a son, William Singleton Pumpelly.

As a young man, Dr. Pumpelly was interested in chemistry and pharmacy and, during the Spanish-American War, saw service with the Navy from which he was discharged as apothecary in 1898. Following his naval service he began the study of medicine, receiving his M. D. in 1903 from the College of Physicians and Surgeons, Baltimore, University of Maryland.

Especially attracted to the laboratory side of medicine, he spent two years on the staff of the Georgia State Sanatorium where much of his attention was directed to pathological work. Later he was for two years on the faculty of Mercer University where he taught pharmacy. His ability and thoroughness brought him wide recognition as an internist and he organized and headed the Clinic Hospital, a Macon institution.

During the years of his professional activity, Dr. Pumpelly spent much time in study which took him to the best clinics in this country and abroad. Time was spent at such centers as Harvard, Saranac, the Mayos and the New York Postgraduate, in clinics in Baltimore, Edinburgh, London and Berlin.

Early in the World War, with the rank of Captain, he was assigned to duty at Columbia, S. C., and later to the staff of the Walter Reed Hospital, where he served as Assistant to the Chief of the Medical Service.

While a real student of scientific medicine, he found time for other things, being a student of English literature, French and Spanish. He was the author of many valuable papers on chest, cardio-vascular nephritic and gastro-intestinal conditions.

It has been said that "he was a recognized authority in ceramics, in painting and knew Oriental rugs as do few men. He was a collector of all these and prized his specimens with a connoisseur's devotion."

At one time he was actively interested in the Shrine and contributed much to its success.

A victim of a cardiac disease, he was forced to give up active work some years ago and recently has been making his home in Fort Pierce where, though physically handicapped, he was recognized as a diagnostician of unusual ability. His passing is a great loss to the medical profession.

BUNDY ALLEN

The medical profession as well as his many friends suffered a deep loss in the death of Dr. Bundy Allen, of Tampa, on November 25th in Gainesville, Florida. Dr. Allen died as a result of injuries sustained in an automobile accident.

Dr. Allen was born in Carbondale, Illinois, in 1885. He received his education at the Carbondale public schools, took a pre-medical course at the University of Indiana and received an M. D. degree in 1912 from St. Louis University, St. Louis, Missouri. After practicing medicine for two years in St. Louis, he went to the University of Iowa where he was head of the Department of Roentgenology for eleven years. He married Miss Edith Cocherrom in Iowa, December 23, 1912.

In 1925 Dr. Allen moved to Tampa from Iowa and began practicing medicine, confining his practice exclusively to x-ray and radium work. He was a member of many organizations, including the Southern, Florida State and Hillsborough County Medical Association; Radiological Society of North America, of which he was a former president; American College of Radiology, American Roentgen-Ray Society, American Medical Association and Royal Society of Roentgenology of England. He was a Rotarian, a Mason and a Shriner, Former president of the First Federal Saving and Loan Association of Tampa and a lieutenant-colonel in the officers' reserve corps.

FRANK GALE RENSHAW

Frank Gale Renshaw was born in Pensacola, Florida, August, 1856. A direct descendent of Captain Eugenia Sierra, a physician who accompanied the original Spanish occupants of the ancient city of Pensacola, he was the son of

Captain Frank B. Renshaw of the United States Navy. It is interesting to note that his middle name was given him because he was born during a terrific storm.

Dr. Renshaw was a graduate of Tulane. For more than half a century Dr. Renshaw was prominent in professional, social and civic activities of his community and a leader in many of its propressive movements. He was Division Surgeon for the L. & N. railroad for more than 45 years, being associated in his younger years with Col. Wm. D. Chipley, founder of the old Pensacola & Atlantic railroad, when the line was being constructed through Northwest Florida. Although he had served as a city councilman and was a member of the Pilot's Commission at the time of his death, Doctor Renshaw had declined many political honors. He was known to almost every man, woman and child of the community, was outspoken in regard to his ideals and was a good citizen. He retired from active practice in 1900, but retained his position with the railroad until his death.

His wife was Fannie Steen of St. Louis, daughter of General Early Steen of St. Louis. Dr. Renshaw's health was generally good until the death of his beloved wife about two and one-half years ago. His last illness began on Labor Day morning when he went home feeling ill and his condition was soon diagnosed as critical. He was conscious and cheerful until a short time before his death. He died September 11, 1935, at 9:10 a. m.

His children are: Frank S. Renshaw of Pensacola, Mrs. George C. Willings of Pensacola, and Mrs. D. F. Maguire of Boston.

Escambia County Medical Society was honorary bearers, and active bearers were selected members of the Elks Lodge of which Dr. Renshaw was a prominent member.

Dr. Renshaw was elected a Life Member of the Florida Medical Association at the 1935 Annual Meeting held in Ocala.

WANTED—An assistantship or partnership with a physician or group. I am 36 years of age and married. Have a Florida license. Have had five years of General Practice and five years of specialty (ear, nose and throat). Postgraduate study in otolaryngology abroad and as a member of staff of three large hospitals in New York. Certified by the American Board of Otolaryngology. Write No. 12-1, care Journal of Florida Medical Association, Box 1018, Jacksonville.

COMPONENT COUNTY SOCIETIES

DADE COUNTY MEDICAL SOCIETY

At the December meeting of the Dade County Medical Society, the election of officers for 1936 took place. The following doctors were chosen.

President—John E. Hall, Miami.

Vice-President—Harrison A. Walker, Miami Beach.

Secretary—M. E. Threlkeld, Miami.

Treasurer—H. A. Barge, Miami.

DUVAL COUNTY MEDICAL SOCIETY

At the December meeting of the Duval County Medical Society, held at the Mayflower Hotel, December 3, the election of officers resulted as follows:

President—W. M. Shaw.

President-elect—Kenneth Morris.

Vice-President—Charles Mabry.

Secretary—H. W. Porter.

Treasurer—John W. Hayes.

After his induction into office, Doctor Shaw announced the personnel of the Society's committees for the coming year, as follows:

Medical Economics Committee: Kenneth Morris, chairman; J. Knox Simpson, Edward Jelks, A. D. Stollenwerck, W. G. Harris, T. G. Croft and F. G. Oetjen.

Certified Milk Committee: Clayton E. Royce, chairman; T. M. Palmer, Paul Eaton and Luther W. Holloway.

Federal Relief Advisory Committee: E. W. Veal, chairman; Paul Martin, and George Croft.

Public Relations Committee: T. E. Buckman, chairman; Louie Limbaugh, and T. S. Field.

Entertainment Committee: George Richardson, chairman; V. A. Hughes, R. R. Killinger, H. B. McEuen and J. V. Safer.

Public Health and Legislation Committee: T. Z. Cason, chairman; Henry Hanson, J. G. Lyerly and E. C. Swift.

Fraternal Relations Committee: L. Y. Dyrenforth, chairman; Banks Goodale, W. W. Kirk, J. B. Parramore, and Russell H. Dean.

Scientific Program Committee: Charles Mabry, chairman; H. W. Porter and Frank Slaughter.

Parliamentarians: Edward Jelks and R. H. McGinnis.

ESCAMBIA COUNTY MEDICAL SOCIETY

THE ESCAMBIA COUNTY MEDICAL SOCIETY HAS REPORTED 100% DUES PAID FOR 1935. THIS SOCIETY HAS AN ACTIVE MEMBERSHIP OF 37 PLUS ONE LIFE MEMBER. THE OFFICERS WHO HAVE GUIDED THE SOCIETY DURING 1935 ARE:

President—M. A. LISCHKOFF.
Vice-President—N. L. GACHET.
Sec'y-Treas.—J. M. HOFFMAN.

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY

A quarterly meeting of the Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society was held in the Elks Club, Tallahassee, Thursday, October 17, at 3:00 p. m. The following scientific program was presented:

"Heart Pathology," E. F. Wahl, Thomasville, Ga.

"Some Observations on Fractures Treated at the Florida State Hospital," J. C. Robertson, Chattahoochee.

"Remarks on Surgery in the Mentally Sick," J. H. Pound, Chattahoochee.

"Some Observations on Blood Pressure," J. G. Gainey, Blountstown.

Following the scientific program, election of officers was held. The following were elected:

President—R. F. Godard, Quincy.
Vice-President—J. M. Beggs, Chattahoochee.
Sec'y-Treas—B. A. Wilkinson, Tallahassee.

PINELLAS COUNTY MEDICAL SOCIETY

At its December 6th meeting, the Pinellas County Medical Society was host to the members of the Hillsboro County Medical Society. The scientific program consisted of papers by Hillsboro Society members, as follows:

"The Classification and Treatment of Anemia," W. C. Blake, Tampa.

"Report of a Case of Siamese Twins," R. G. Nelson, Tampa.

"An Analysis of 597 Cases with Chest Pain, Suggestive of, but not Coronary Sclerosis," E. W. Bitzer, Tampa.

"The Part that Vitamin 'D' Milk has Assumed in Pediatric Practice," D. D. Martin, Tampa.

"Dangers and Safeguards in the Administration of Immune Sera," F. C. Metzer, Tampa.

WOMAN'S AUXILIARY

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MRS. L. C. INGRAM, Finance . . . . . *Orlando*
MRS. S. M. COPELAND, Press and Publicity . . . . *Jacksonville*

MARION COUNTY AUXILIARY

Mrs. R. D. Ferguson entertained the members of the Marion County Medical Auxiliary at the Highlands Hotel September 26th. A delicious luncheon was served at one o'clock. The ladies were seated at a large table centered with a beautiful floral design in autumn tints and served a most tempting menu.

A business meeting was held immediately following the luncheon at which time the president, Mrs. R. D. Ferguson, presided. This being the first meeting of the year Mrs. Ferguson announced her committee personnel, Mrs. H. C. Dozier, chairman public relations, Mrs. E. G. Lindner, social, Mrs. Tom Wallis, historian, Mrs. J. N. Moore, publicity, and Mrs. R. C. Cummings, Hygeia.

Much time was devoted to planning a cancer control program to be given in November. The organization expects to promote cancer control education in the public schools and bring interesting facts before other organizations throughout the county. A program has been arranged for each county P. T. A. some time during the year.

Each county high school has been given a year's subscription to Hygeia on the condition that each school give at least one program from each issue.

The new members of the executive board for the coming year are: Mrs. R. D. Ferguson, president; Mrs. J. L. Strange of McIntosh, vice-president; Mrs. J. N. Moore, secretary, and Mrs. H. C. Dozier, treasurer.

The Marion County Medical Society and the Auxiliary had a delightful get-together time Oc-



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tober 18th, at the home of Dr. and Mrs. E. G. Lindner on East Fifth St. A short business session for each body was scheduled for 6 o'clock, followed by a covered dish supper provided by members of the Auxiliary.

At the ladies' meeting, plans were perfected for the cancer control program which is the special work of the auxiliary for the year, as requested by the State Medical Association. It is county-wide in scope and is to be worked partly through the schools, the various physicians contributing educational lectures from time to time.

One of the jolly features of the supper, which was spread on the lawn, was the "Happy Birthday to You" greeting in song that met Dr. H. C. Dozier, while a big birthday cake was placed before him, the news of the anniversary having leaked out.

Later in the evening card games were enjoyed by the following: Dr. and Mrs. J. L. Strange of McIntosh, Dr. and Mrs. R. D. Ferguson, Dr. and Mrs. H. F. Watt, Dr. and Mrs. Ralph E. Russell, Dr. and Mrs. H. C. Dozier, Dr. and Mrs. R. C. Cumming, Dr. and Mrs. J. N. Moore, Dr. Tom Wallis, Dr. J. L. Chalker and Dr. E. G. Peek.

Guests invited were Captain and Mrs. Banton and Dr. and Mrs. Shepard, connected with the canal medical staff; Dr. M. C. Izlar, Miss June Rhody and Mr. and Mrs. John A. Bowman.

* * *

Orange County Auxiliary

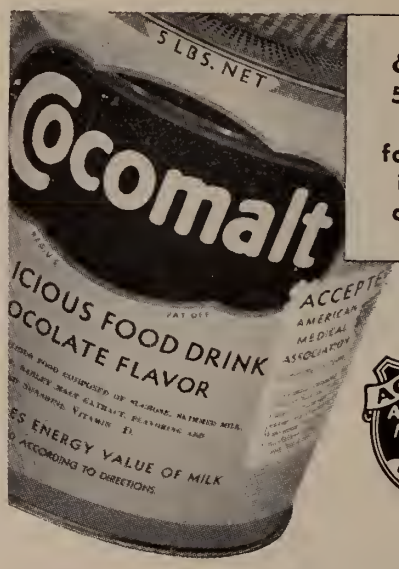
The September meeting of the Orange County Medical Auxiliary was held at the home of Mrs. Carl D. Hoffmann with the president, Mrs. L. C. Ingram, in the chair.

Mrs. Ingram told of her plans for the Auxiliary, and gave a brief outline of the work to be carried on this year. It was decided that an informal meeting of the Orange County Medical Society and the Woman's Auxiliary would be held in November.

A social hour followed after which the meeting was adjourned.

The Orange County Medical Society were guests of the Woman's Auxiliary on Thursday evening, October 31st, when a barbecue was staged at Dr. and Mrs. C. D. Christ's camp on Lake Holden.

Knowing that Brunswick stew was a favorite dish with most of the doctors, the entertainment



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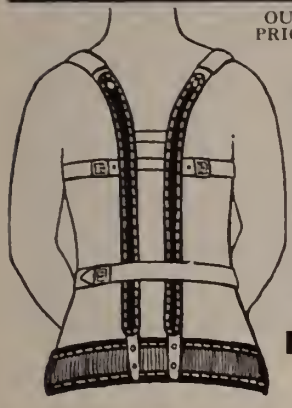
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After supper, the evening was devoted to dancing, and from all appearances, the good old square dance is still very popular.

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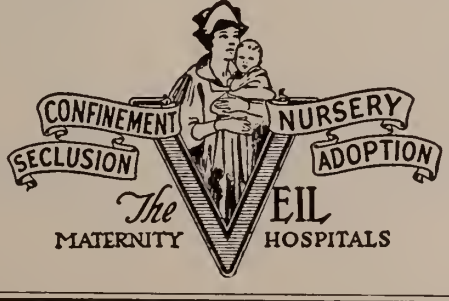
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The list of speakers who will appear on various programs includes Senator William E. Borah, Senator Gerald P. Nye, Former Governor Alfred E. Smith, and William E. Green. Among writers who will contribute original dramas as well as special adaptations of successful Broadway productions are Sidney Howard, Humphrey Cobb, Fannie Hurst, Rupert Hughes, Zoe Akins, Maxwell Anderson, Zona Gale, F. Scott Fitzgerald, John Erskine, Heywood Broun and S. S. Van Dine. Musical entertainment on the programs will include such stars as Lucrezia Bori, Jascha Heifetz, Edward Johnson, Greta Stueckgold, George Gershwin, Richard Crooks, Albert Spalding, Lotte Lehman and Richard Bonelli. Deems Taylor will be master of ceremonies on all programs and Howard Barlow will conduct the symphony orchestra and a vocal chorus.

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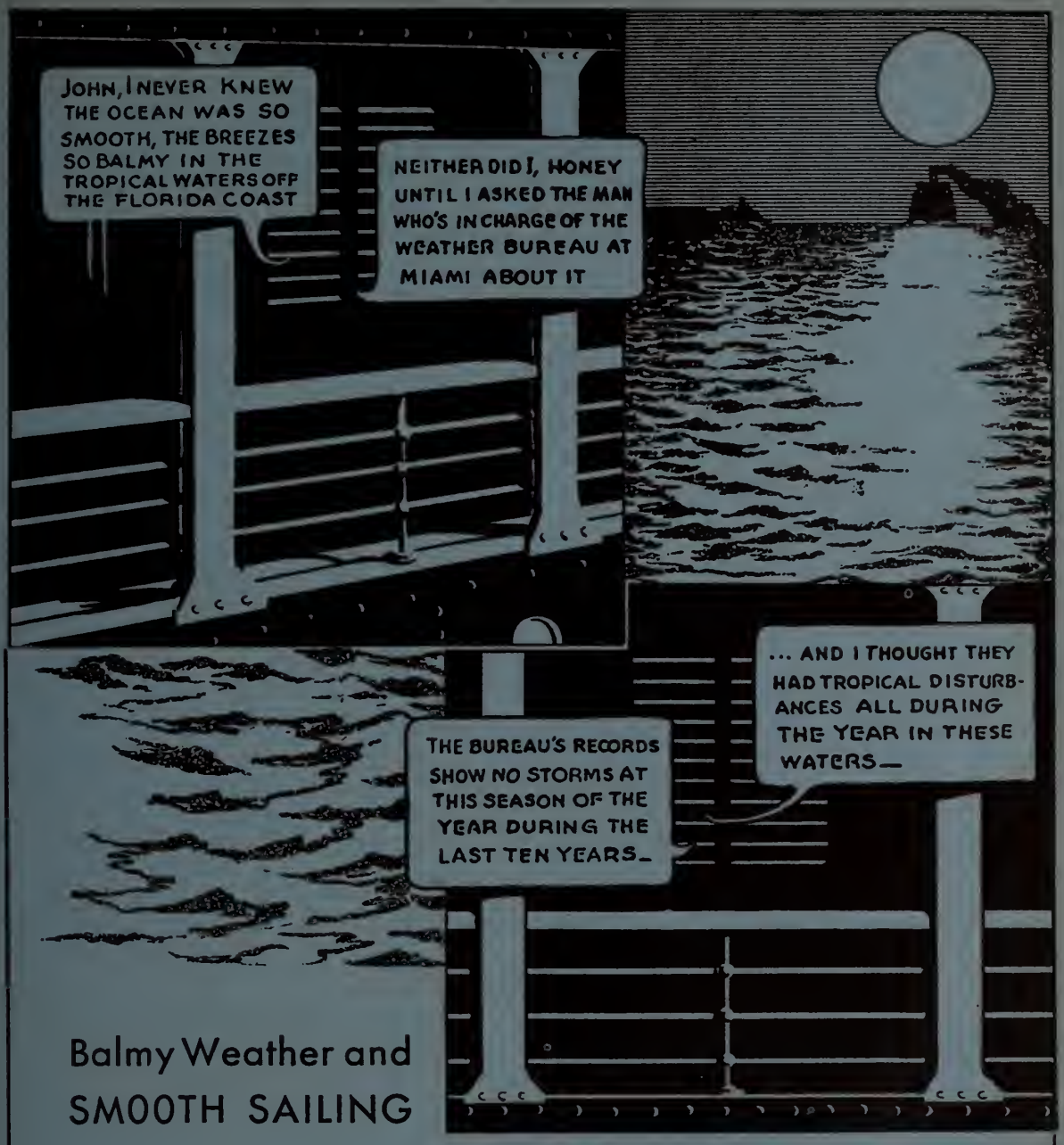
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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	J. E. Maines, Jr., M.D., 331½ W. University Ave., Gaiuesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Tuesday 12:00 noon	White House, Gainesville	23	92%
Bay	W. C. Roberts, M.D., Panama City	Allen H. Miller, M.D., Millville			8	80%
Brevard	I. K. Hicks, M.D., Melbourne	Bob Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies	7	77%
Broward	O. C. Brown, M.D., 915 Sweet Building, Fort Lauderdale	R. E. Blount, M.D., 360 S. E. 26th Ave., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale	22	100%
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	10	100%
Dade	John E. Hall, M.D., Box 2722, Miami	M. E. Threlkeld, M.D., Congress Bldg.. Miami	1st Friday 8:30 P.M.	Club Rooms Huntington Bldg., Miami	209	99%
DeSoto-Hardee-Highlands	C. H. Kirkpatrick, M.D., P.O. Box 454 Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies	19	100%
Duval	W. M. Shaw. M.D., St. James Bldg., Jacksonville	H. W. Porter, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	115	78%
Escambia	M. A. Lischkoff, M.D. Blount Bldg. Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola	37	100%
Hillsboro	G. C. Bottari, M.D., 1425½ E. Broadway Tampa	John S. Helms, Jr., M.D., P. O. Box 1439 Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa	110	92%
Jackson	C. C. Box, M.D., Graceville	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna	10	92%
Lake	J. D. Coupland, M.D., Eustis	W. L. Ashton, M.D., Umatilla	1st Thursday 12:30 PM.	Eustis	18	95%
Lee	Ernest Bostelman, M.D., 201 Pythian Bldg., Fort Myers	H. Quillian Jones, M.D., 18-20 Leon Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers	10	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	R. F. Godard, M.D., Key Building, Quincy	B. A. Wilkinson, M.D., Telephone Bldg., Tallahassee	Quarterly 3:00 P.M.	Varies	28	82%
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison			3	100%
Manatee	H. Gates, M.D., P. O. Box 245 Bradenton	W. D. Sugg, M.D., Bradenton Bank Bldg., Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Club Bradenton	9	75%
Marion	J. L. Chalker, M.D., 719 E. Oklawaha Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala	19	100%
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies	3	100%
Orange	T. M. Rivers, M.D., Kissimmee	J. A. Pines, M.D., 106-10 E. Central Ave., Orlando	3rd Wednesday 8:30 P.M.	Varies	51	100%
Palm Beach	W. W. George, M.D., 1116 Harvey Bldg., West Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach	53	100%
Pasco-Hernando-Citrus	R. D.Sistrunk, M.D., Dade City	John J. Bourke, M.D., Dade City	2nd Thursday 7:00 P.M.	Varies	13	100%
Pinellas	F. E. Kauffman, M.D., Coachman Bldg., Clearwater	W. C. McConnell,. M. D. 1005 Equitable Bldg. St. Petersburg	1st Friday 8:00 P.M.	Assembly Room, 5th Floor, P. & L. Bldg., St. Petersburg	75	95%
Polk	R. L. Hughes, M.D., 225 E. Main St., Bartow	J. R. Boulware, Jr., M.D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P.M.	Lakeland	67	100%
Putnam	A. E. Drexel, M.D., Palatka		2nd Tbursday 7:00 P.M.	James Hotel, Palatka	6	86%
St. Johns	Reddin Britt, M.D., P. O. Box 1226, St. Augustine	John L. Bennett, M.D., St. Augustine	3rd Tuesday 8:30 P.M.	Varies	11	100%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., P. O. Box 942, Stuart	E. B. Hardee, M.D., Vero Beach	3rd Thursday 8:00 P.M.	Varies	12	86%
Sarasota	C. B. Wilson, M.D., 1st B. & Tr. Bldg., Sarasota	J. E. Harris, M.D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P.M.	Varies	14	93%
Seminole	C. L. Park, M.D 515-6 1st Bank & Tr. Bldg. Sanford	J. T. Denton, M.D., Meisch Bldg. Sanford	2nd Monday 7:00 P.M.	City Hospital Sanford	11	100%
Sumter	A. B. Albritton, M.D., Wildwood	W. E. Mitchell, M.D., Box 237 Coleman	2nd Tuesday	Varies	5	100%
Taylor	W. J. Baker, M.D., Foley	C. A. O'Quinn, M.D., Perry	Last Friday 8:00 P.M.	Dixie-Taylor Hotel, Perry	7	100%
Volusia	G. A. Davis, M.D., Dreka Bldg., DeLand	Hugh West, M.D., DeLand	2nd Tuesday 7:30 P.M.	Varies	35	90%
Walton-Okaloosa	E. L. Huggins, M.D., Freeport	A. G. Williams, M.D., Lakewood	3rd Thursday 8:00 P.M.	Varies	6	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



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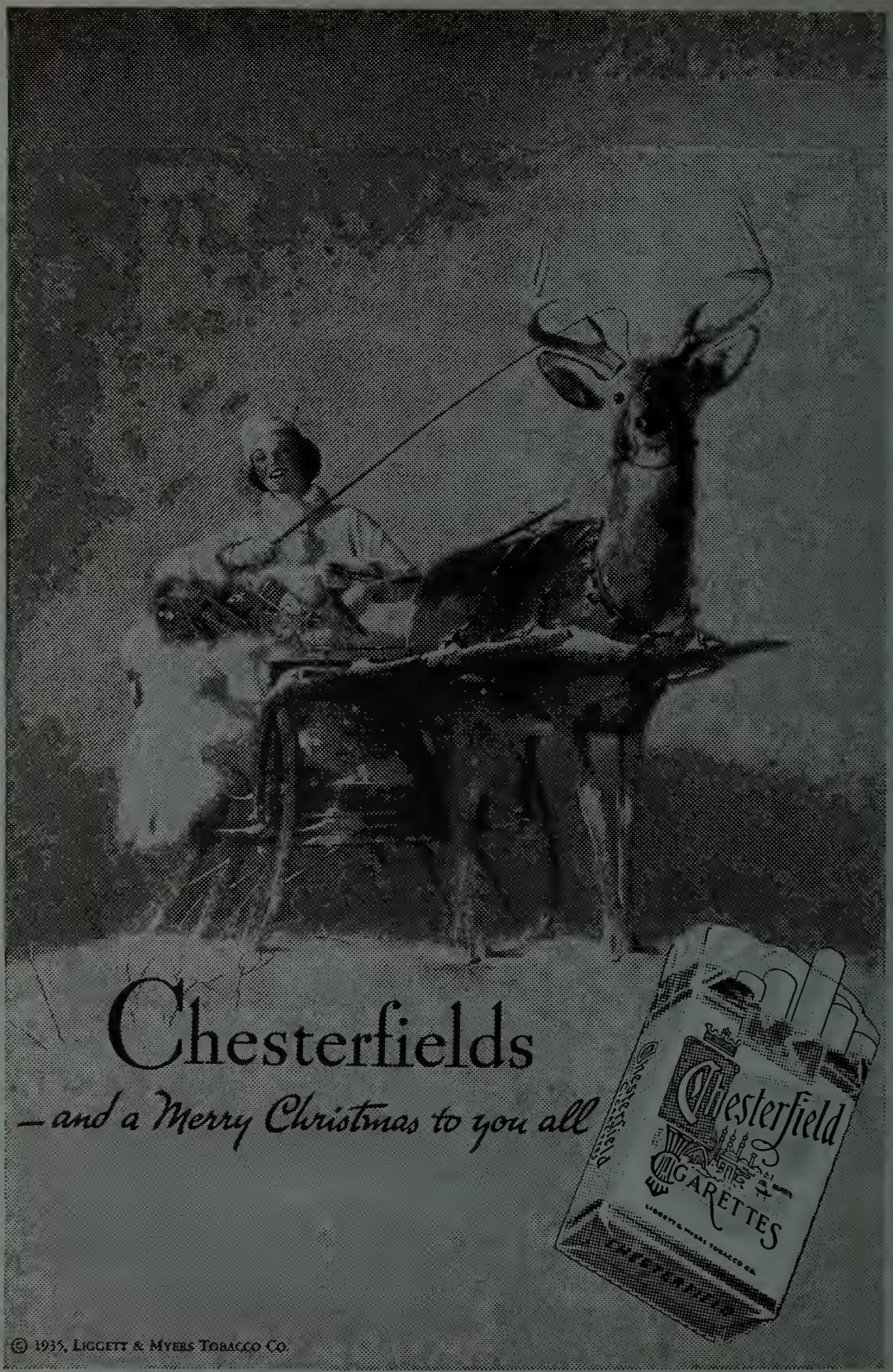
on a 3 DAY TROPICAL CRUISE

•

PLANS now under way promise smooth sailing for the Sixty-third Annual Meeting of the Florida Medical Association, Inc.

Records of the weather bureau at Miami and at Key West promise smooth sailing for the luxuriously appointed liner "Florida" on which the convention meeting will be held during a three-day cruise . . . no tropical disturbances have been experienced in the Miami-Key West area during April in the past ten years.

And the average temperature for April (73.8 degrees for Miami; 76.0 degrees for Key West) promises cool comfort in the spacious ballroom, salons and other meeting places on board the cruise ship where delegates will read, listen and talk about medical, scientific and economic subjects that will broaden their vision and add to their store of scientific knowledge.



NEW YORK ACADEMY OF MEDICINE
2 E 103RD ST
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THE JOURNAL
— OF THE —
Florida Medical Association, Inc.

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION, INC.

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NEXT SESSIONS

Florida Medical Association, S.S. Florida, April 27, 28, 29, 1936.
American Medical Association, Kansas City, Mo., May 11-15, 1936.
Southern Medical Association, Baltimore, Md., November 17-20, 1936.

Entered as second-class matter under Act of Congress of March 3, 1879. at the Postoffice at Jacksonville, Florida, October 23, 1924

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THE CANNING PROCEDURE

• Some misunderstandings exist as to the mechanics of the commercial canning procedures. Although some such information is available (1) (2), it is not surprising that the facts are not more generally known. The art of canning has been largely developed by, and retained within, the industry.

Of necessity, canning procedures vary with the product packed. However, it is possible to indicate in broad detail the treatment to which foods may be subjected during canning.

Cleansing Operations

Raw materials are given a thorough water cleansing, usually by washing under high pressure sprays.

Preparatory Operations

Following washing, undesirable stock is removed by sorting, trimming, peeling and coring operations, as occasion may demand. With some products these operations are performed mechanically.

Blanching

Certain products are "blanched" or scalded by immersion in hot water. This process serves not only to clean the product further, but also to soften the tissues and expel air therefrom.

Preheating and Filling Operations

Here practice varies with the product. Sometimes the food is precooked and filled into cans; again, it may be filled into cans and hot water or hot salt and/or sugar solutions added; still again, the filled cans are "exhausted" in a steam or hot water box. All these operations, the majority of which are mechanically performed, serve to preheat the product and exclude air from the cans.

Sealing, Processing and Cooling Operations

The filled cans are hermetically sealed on an automatic "closing" machine while the contents are still hot; the sealed cans are then heat processed to destroy spoilage micro-organisms; finally, the cans are cooled in water or air. Cooling contracts the contents and produces a vacuum within the can.

Such are the broad details of the canning procedure. We trust this brief word picture will bring better understanding of the treatments to which canned foods are subjected.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) 1924, Commercial Fruit and Vegetable Products, W. C. Cruess, McGraw-Hill, New York

(2) 1924, A complete Course in Canning, The Canning Trade, Baltimore

This is the eighth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

ACCEPTED AMERICAN MEDICAL ASSN. Committee on Foods

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Committee on Foods of the American Medical Association.

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(Penna. State Med. Jour.; Oct. 1935.)

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(Med. Record, Dec. 5, 1934.)

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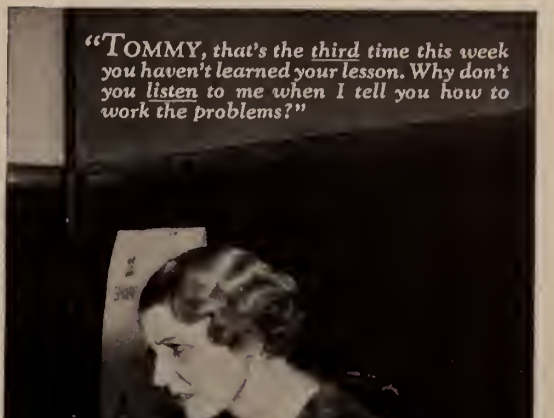
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Pablum (Mead's Cereal, thoroughly cooked) is a palatable cereal enriched with vitamin- and mineral-containing foods, consisting of wheatmeal, oatmeal, cornmeal, wheat embryo, alfalfa leaf, beef bone, brewers' yeast, iron salt, and sodium chloride.

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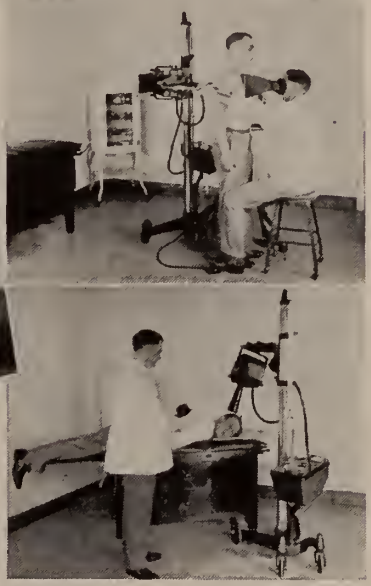
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—Kugelmass, Clinical Nutrition in Infancy and Childhood (p. 53)

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXII | Jacksonville, Florida, January, 1936 | Number 7

INFECTIONS AND TREATMENT OF THE CERVIX UTERI*

W. C. Payne, M.D.,
Pensacola.

It is estimated that from seventy to eighty-five per cent of all women have chronic infection of the uterine cervix. It is a disease of the greatest importance to any physician assuming the responsibility of treating women patients. If it were practical for all these patients to consult gynecologists, there would be no excuse for the presentation of this paper. What I have to say is well known to everyone specializing in diseases of the female pelvic organs. It is the general practitioner, however, who is consulted by the vast majority of patients who need treatment for a chronic cervicitis. It is my purpose to emphasize the fact that there exists a safe, simple and efficient method of treating these cases and that this treatment can be done in the office and will give satisfactory results in most cases. There is a certain number of patients, however, who have such badly diseased cervices that they will require hospitalization and more radical treatment than can be given in the office.

When most of us began our practice, we were taught that pelvic infections began as an endocervicitis and extended up the uterine cavity as an endometritis and thence out through the fallopian tubes to the ovaries. Curtis showed us, however, that pelvic infections begin, in most instances, as an endocervicitis and extend to the myometrium and uterine adnexa by way of the lymphatics and that endometritis is an extremely rare condition. It has also been demonstrated that severe infection of the pelvic structures is not the result of a single acute infection but of many acute infections or a chronic infection over a long period of time. There is no question but that there are many patients suffering with pelvic infections who are subjected to laparotomy and removal of all or a greater part of the uterine adnexa where the proper treatment of an infected cervix, which is the real source of the trouble, would suffice. Of course, if the cervicitis has been neglected over a long period of time, the uterine adnexa may become so diseased that nothing short of surgical removal will offer relief. The point that I am trying to make is that practically all pelvic infections can be prevented by the proper treatment of an infected cervix. An infected cervix is not only the source of pelvic infection but may also be the focus of systemic infection, particularly of the joint and eye. It is hard to understand how often this fact is overlooked. It is a common occurrence that a patient presenting evidence of a systemic infection is subjected to a very thorough examination by the dentist, the nose and throat specialist, the gastro-enterologist, etc. And yet the cervix, which is more frequently infected than any other part of the body, is not examined.

Doctor Curtis has shown us that leukorrhea is caused usually by an endocervicitis or by an infection of Skeen's glands or both. We formerly thought that this condition resulted from an endometritis or a vaginitis. We now know that except in a gonorrheal vaginitis or a vaginitis caused by the trichomonas vaginalis that the vagina is not the cause of leukorrheal discharge. We also know that the mucus plug that results from an infection of the cervical glands is often the cause of sterility.

ETIOLOGY

Everyone accustomed to making vaginal examinations is so familiar with the picture presented by the chronically inflamed cervix that I do not think it is necessary to describe the symptoms. The organisms usually found are the gonococcus, the streptococcus, the staphylococcus and the colon bacillus. The predisposing cause, except in gonorrhea, is trauma from childbirth or from instrumentation.

HISTOPATHOLOGY

We know that the cervical canal is lined with columnar epithelium containing racemose glands and that the portio is covered by squamous epi-

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thelium. We know that trauma and laceration of the cervical mucous membrane allows the entrance of infection into the glands of the cervical canal. We know that the resultant mucopurulent discharge causes denudation of the squamous epithelium covering the portio and that since the columnar epithelium of the canal is more resistant to this discharge, it grows down with its racemose glands to cover the denuded portio, and that this presents a picture commonly called erosion of the cervix. As the infection of the cervical canal and its consequent discharge gradually improves, the squamous epithelium begins to spread back over the portio and in so doing it covers the columnar epithelium with its racemose glands. The ducts of the glands are thus occluded but the glands continue to secrete, forming cysts known as Nabothian cysts. We know that it is only a step from these displaced, normal cells with orderly arrangement to disorderly arrangement with embryonal cells of true malignancy.

Puerpural infections are sometimes caused by bacteria which have been present in the cervix a long time before labor. Such cases could have been prevented by the proper treatment of a chronic endocervicitis.

TREATMENT

The objectives of treatment of infections of the uterine cervix are: first, to relieve a leukorrheal discharge; second, elimination of the source of most of the infections of the uterine adnexa; third, elimination of a possible source of systemic infection; fourth, removal of a lesion which may be precancerous; fifth, efficient treatment of sterility in many cases.

It is generally known that the proper treatment of chronic endocervicitis would accomplish the above objectives. Why is it, then, that the family physician fails so often to properly treat these cases? I believe that there are several reasons. He realizes that the methods he has been employing consisting of topical applications, tampons, douches and suppositories are worthless or at best, woefully inefficient. He is confused by the several physical modalities advocated in the treatment of chronic endocervicitis. He doubts his ability to use either method properly. The complications which may follow the use of either method have been exaggerated in his mind. It is not the object of this paper to make a comparison of the various methods at our disposal. I have had no experience with the use of radium as advocated by Curtis nor the conization method of Hyams. My experience with electrocoagulation has been too limited to permit me to draw conclusions. For several years I have been using the electric cautery. It has the advantage of being simple and economical. A small transformer and an ordinary nasal tip can be obtained from any instrument house. The handle should have a finger switch which controls the current.

An important part of the treatment is the proper handling of the patient. She should be told frankly what you propose to do and that she will experience some discomfort. She should be assured, however, that the pain will not be severe and that the current will be turned off any time she requests it. And this should be done. If nothing is accomplished at the first sitting except to gain her confidence, it will be worth while. At the next sitting she will permit more treatment without complaint. I have never found it necessary to use an anesthetic for office treatments, even in the most nervous patients.

TECHNIQUE OF ELECTROCAUTERIZATION

When electrocauterization was first called to my attention, I read all I could find about the technique. I noticed that most writers advocated striping of the cervix by lines of cauterization made at regular intervals, leaving islands of viable mucous membrane between each stripe, and that the depth of these stripes should be from three to five mm. I was therefore very much discouraged when I began trying this out, because while it looks good on paper, I have never been able to do it satisfactorily. We find that no two cervices are exactly alike; that some are not lacerated, others show various degrees of laceration and are of various sizes. Naturally, some contain Nabothian cysts and a severe grade of chronic infection, while others show only a superficial erosion. I do not see how one can work out any one technique applicable to all these cases. It is my opinion that the mistake that is most often made is being too enthusiastic and trying to do too much at one sitting. I believe it is best for the beginner to be very cautious and to do too little rather than too much. Experience will soon show him how much is safe to do at one time. The area cauterized should always be allowed to entirely heal before another cauterization is done. This usually requires about four weeks, sometimes longer. It is the

writer's practice, after the cervix has been exposed, if there are any cysts present, to puncture each of them with the cautery tip and then to cauterize only one lip of the cervix at one treatment. In this way, there is no danger that the entire circumference of the cervical canal may be cauterized at one time, thus minimizing the chances of a stricture. The cold cautery tip is introduced up to the internal os and is held against either the posterior or anterior wall of the canal. The current is then turned on and the tip gradually brought out over the infected area of the cervix. The entire surface of the lip of the cervix which is being treated is cauterized and no attempt is made to leave any viable mucous membrane on that wall of the cervical canal. One month later the other lip of the cervix is treated similarly. This procedure is repeated, alternating the anterior and posterior lips until all evidence of infection has subsided.

CONTRAINDICATIONS

Cauterization of the cervix with an electric cautery is contraindicated in acute and subacute infections of the cervix and uterine adnexa. It is also contraindicated in the latter weeks of pregnancy. Some authorities consider it contraindicated in any stage of pregnancy.

COMPLICATIONS

The complications which may follow the use of the electric cautery on the cervix are secondary hemorrhage and stricture of the cervix. I believe that the danger of both of these complications can be reduced to a minimum by a proper and cautious technique.

In conclusion I wish to emphasize the fact that every postpartum patient should be examined six weeks after delivery and again at three months, and if there is any evidence of a cervical infection, it should be properly treated. Every obstetrician should realize that he has not fully discharged his obligation to his patient until he has assured himself that the cervix is in a healthy condition.

DISCUSSION

Dr. J. M. Hoffman, Pensacola:

Dr. Payne's paper should certainly draw the attention of every practitioner of medicine. It is not only the gynecologist that should have this matter in mind, but every specialty. He mentioned casually an eye condition that can be traced as a focus of infection to cervical conditions and infections. No examination for focal infection in women should be complete without a thorough examination of the cervix.

In regard to the technique of treatment; my own experience is confined principally to the use of the high frequency current electrocoagulation. For a time I used radium, but I found that the electrocoagulation is so much more satisfactory, so much easier to apply, and requires a much less period of time than radium, that I use radium no more. I use a high frequency current and introduce the cautery within the internal os. Experience teaches us that it must be used carefully. Necessarily we don't use a very heavy current that would cause necrosis of a large area of the cervix because of the danger of later stricture. I have found that the patient will not flinch under this treatment. It is usually painless and no anesthetic is necessary. Very often one application is sufficient to clear up an early diseased cervix. Where there is a cyst I usually puncture the cyst with the tip of the cautery and the condition usually heals up with very little scarring.

In conclusion I think it would be wise to emphasize again the necessity of a thorough examination of the cervix as a post-partum routine both at six weeks and again at three months. We cannot over-emphasize the possibility of systemic infections resulting from an unrecognized cervical infection. Also the later possibility of malignant changes taking place in an old eroded cervix is sufficient to keep us all on the watch. The time to clear up these conditions is before malignant changes have taken place.

Dr. J. S. Turberville, Century:

Dr. Payne has covered the subject so well that he has left very little for discussion, but I wish to emphasize some of the points made in his paper.

In the first place, he spoke of an office procedure. He was speaking of the fractional treatment, something that can be done in the office. His conservatism is certainly brought out by use of fractional cauterization, that is, cauterizing a little at a time and watching results. Those of us who have had some of the accidents due to radical work can appreciate fully what he is speaking of. If you do too much you are apt to have infection and fever. The vagina is full of

bacteria at all times, and in cases where there is not acute inflammation, but in which there is too radical treatment, necrosis and infection may develop and then later, sometimes after ten days, you may have a severe hemorrhage. When you have to go twenty-five or thirty miles to pack a woman, she will be almost exsanguinated when you get there. Therefore, I would stress this point: do not do too much at one time and keep her where you can get to her early, or something is apt to happen.

Dr. Payne did not go into symptomatology a great deal. There are a few points I would like to bring out, but I particularly want to emphasize the care with which he presents this paper. If you follow what he says you should have no trouble, but if you do not do what he tells you, you will get into trouble.

Many women have lower abdominal pains, particularly over the sides, headaches, painful sexual intercourse, etc. They are often subjected to operations on tubes and ovaries. The measures advocated by Dr. Payne will relieve many of these cases. I am speaking of subacute pelvic infections. Acute pelvic infections should not be treated by cauterization until they clear up sufficiently.

In cases of laceration from childbirth, sometimes we are surprised at the size of the cervix. You may have to go after these a number of times because you have many hidden Bartholin cysts, sometimes a fourth of an inch from the margin. These are cases where you get some fine results from cauterization, but no results whatever from repair of the cervix, because the cervix will not hold. You have noticed patients coming in who say they have had a repair of the cervix and you find it standing wide open. There is but one plastic operation that is worth while on these cases, and that is Sturmdorf's. However, I think that close attention and repeated cauterization will give better results than any plastic operation.

Dr. H. A. Day, Orlando:

To me this is one of the most important subjects that can ever be discussed before a medical meeting, because it is one of the most frequent diseases we find.

Every case of endocervicitis is a problem within itself. In the treatment we must be guided by the pathological condition we find present. I agree with Dr. Payne that small erosions that occur on the cervix can be cured by cauterization. But when you find a large swollen cervix full of cysts, dilated glands, and hyperplastic mucous membrane within the glands, I don't believe that cauterization will ever cure it. In these cases I think you should do a coning out of cervix with electric knife or else do a Sturmdorf operation.

We all know that the cervix has been called the tonsil of the pelvis. I firmly believe that is because of the lymphatic drainage, which goes around every blood vessel in the uterus and broad ligament, around the ovaries and also drains into the lymphatic glands in the pelvis and abdomen. In operating on these cases of chronic endocervicitis if you will take out a segment of of the uterus and a little bit of the broad ligament, make a section and put it under the microscope you will find a lymphocytic infiltration around the blood vessels, showing a drainage from toxins to be from this region. What does this mean? It means that you get a varicosity of the broad ligament, and a thickening of the covering of the ovaries which later may produce an ovarian cyst.

I just mention these facts because I think it is important that we treat the cervix early as Dr. Payne brought out, important to treat the cervix at six weeks and three months after delivery, and examine it thoroughly.

Dr. W. C. Payne, Pensacola (concluding):

Replying to Dr. Day: I evidently did not make myself sufficiently clear. In fact I did not mean that all cases could be cured in the office, and that the electrocauterization would be sufficient in the most severe cases. I did not mean it as a substitute for the Sturmdorf operation, conization, trachelorrhaphy or other proper treatment in those cases that would not respond to office treatment.

However, in these cases as Dr. Turberville brought out, you would get better results from trachelorrhaphy or whatever plastic you find necessary, if a preliminary office treatment of electrocauterization is given.

I also mentioned that it was not my purpose to say anything against the efficiency of the various forms of treatment. I have had no experience with the conization treatment of Hyams. It may be the best treatment; however, to my mind it requires more technique and more paraphernalia than is now available to the average general practitioner.

THE DIAGNOSIS OF BRAIN TUMOR*

J. G. Lyerly, M.D.,
Jacksonville.

It is essential that an early diagnosis of brain tumor be made as soon as possible so that further damage to the brain and vision can be prevented by adequate treatment. Often a patient is treated for weeks or months for conditions other than brain tumor due to the fact that the symptoms were not properly interpreted, or the patient was not adequately studied. To emphasize the importance of the history and examination the general pressure and focal symptoms will be described briefly.

GENERAL PRESSURE SYMPTOMS

A brain tumor is frequently silent until the symptoms of increased intracranial pressure make their appearance.

Headache early in the morning is a frequent symptom. It may be generalized or limited to a region suggesting the location of the growth. The latter sign cannot be relied upon as the lesion may be far removed from the seat of pain.

Dizziness is frequently associated with headache and it may vary from a subjective unsteadiness to a staggering gait.

Vomiting early in the morning with headache is often found. It is projectile in type and sometimes associated with nausea, but a full meal may be eaten afterwards. Vomiting is an early and frequent symptom of brain tumor in children.

Failing vision due to choked disc and optic atrophy is frequently found with intracranial pressure. An ophthalmoscopic examination is most important and a choked disc should lead one to a correct diagnosis.

Abducens nerve palsy producing an internal squint is a frequent finding. The sixth cranial nerve has a long course in front of the pons where it may be compressed by a transverse branch of the basilar artery in general pressure.

Ringing in the ears with impaired hearing is sometimes found. The eighth cranial nerve may be choked from general pressure like the optic.

Fainting, unconscious attacks and convulsions may be symptoms of pressure. They are similar to those found in epilepsy.

A "crack pot" sound, or Macewen's sign, on percussion of the skull may be found. It is typically present in children when the skull is thinned and the cranial sutures are separated from high intracranial pressure.

The x-ray evidence of general pressure is found in convolutional atrophy and thinning of the skull, separation of the cranial sutures and erosion of the dorsum sellae.

Impairment of memory, dulling of the mental processes and sluggish thinking may also be symptoms of general pressure.

FOCAL SYMPTOMS

An x-ray examination may be conclusive of the nature and location of the lesion by a calcification in the growth. It may show a bony absorption or proliferation of the skull over a meningioma.

With a negative x-ray examination the localization may be made by examination for disturbance of the functions of the different regions of the brain.

Frontal lobe: Impairment of memory for recent events, disorientation for time and place, and personality changes with euphoria and facetiousness are frequently seen. When located on the inferior surface, there may be impairment of smell on the same side, or a Foster Kennedy syndrome manifested by a primary optic atrophy on the same side with a choked disc on the opposite side.

Posteriorly, the involvement of the precentral region will cause weakness of the lower face, arm, or leg on the opposite side. Involuntary urination and defecation, fainting, unconscious attacks, and generalized convulsions are seen in a high percentage of cases.

A lesion of the premotor area may cause forced grasping and groping, manifested by involuntary grabbing and holding an object with the hand. The head and eyes may be turned forcibly to the opposite side with an irritative lesion and to the same side with a destructive lesion. In the left inferior frontal convolution is Broca's area for motor speech in right-handed individuals. Involvement of this area causes a pure motor aphasia manifested by a clear understanding with inability to utter words.

Precentral region: A lesion in this region produces motor symptoms on the opposite side. In the early stage there are irritative symptoms manifested by Jacksonian convulsions starting in a certain part of the body. The convulsion may spread over the same side, or cross to the opposite side when the patient becomes unconscious. There is usually a partial paralysis of the affected extremity showing the lesion is destructive as well as irritative. Jacksonian attacks with progressive paralysis is indicative of a brain tumor.

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Post-central region: The cortical centers for sensation are located in the region just back of the fissure of Rolando. There may be subjective numbness, tingling or parethesias with a few or no objective findings. If impairment is found it involves those sensations which have to do with discrimination, as the inability to tell the position of parts, distance between compass points, difference of weights, texture of material, and the shape and size of objects.

Parietal lobe: Here is the center for stereognosis which is the ability to recognize an object by its feel. In right-handed individuals a lesion may produce apraxia shown by the inability to make proper use of objects. In the posterior parietal region a lesion may cause alexia, or the inability to read, and agraphia, or the inability to write. In the region of the angular gyrus in right-handed individuals there will be nominal aphasia with inability to name objects.

Temporal lobe: The right temporal lobe is one of the silent areas of the brain in right-handed individuals except for a possible visual field disturbance. The optic radiation from the occipital lobe to the external geniculate body passes through the temporal lobe where a lesion may produce a quadrantic defect or an homonymous hemianopsia on the opposite side. There may be contralateral facial weakness from involvement of the adjacent motor area. On the left side there is sometimes aphasia of the syntactical or jargon type and occasionally visual hallucinations of form. With involvement of the inferior mesial aspect of the lobe there may be uncinate attacks manifested by hallucinations of smell and taste and a dreamy or semi-conscious state.

Occipital lobe: In this region is located the primary visual center. A destructive lesion in the region of the calcarine fissure will produce an homonymous hemianopsia on the opposite side without loss of macular vision. Irritative lesions frequently produce flashes of light and colors on the opposite side in contradistinction to hallucinations of form objects in lesions of the posterior temporal region.

Cerebellum: Lesions in this region produce dizziness and unsteadiness from disturbance of equilibrium and coördination. Ataxia is present with jerky movements and over-pointing in the finger to nose and heel to knee and shin tests. There will be adiadokocinesia with inability to perform alternate movements in quick succession. Nystagmus in the horizontal or vertical plane may be found with the coarser element to the side of the lesion. Involvement of the lateral lobe of the cerebellum produces symptoms in the extremities on the homolateral side while in the vermis the trunk movements are affected. The latter is most frequently seen in mid-cerebellar tumors of children. Muscular tone is diminished and the tendon reflexes are sluggish or absent. A patient may hold the neck stiffly with the head tilted to one side. As the pressure in the posterior fossa increases there may be herniation of the cerebellum into the foramen magnum making pressure on the medulla. This sometimes causes cerebellar fits, manifested by retention of consciousness, severe pain in back of the head and neck and opisthotonos with tonic rigidity of the extremities. This is a serious sign and a fatality from medullary compression may result. A spinal puncture in the presence of a high intracranial pressure due to brain tumor may precipitate such an attack.

Third ventricle: Lesions of the third ventricle, in addition to the general pressure symptoms caused by the blockage of the cerebrospinal fluid from the lateral ventricle, may produce localizing signs of involvement of the hypothalamic region shown by increased somnolence, adiposity, polyuria and polydipsia. Tremors, choreiform and athetoid movements with spasticity and rigidity may be seen with involvement of the basal ganglia. Painful areas with impaired sensation and emotional disturbance may be found with involvement of the optic thalamus. Hypopituitary symptoms occur from downward pressure on the sella turcica. In the posterior part of the third ventricle and in the pineal region there may be paralysis of upward movement of the eyes and impaired hearing.

Pontine and Brain Stem Lesions: With involvement of this region there will be paralysis of many cranial nerves from the fifth to the twelfth on one or both sides. In addition there may be motor and sensory disturbances of the extremities with involvement of the cortico-spinal pathways in their passage through the brain stem. Choked discs do not occur unless there is secondary involvement by a cerebellar or a cerebello-pontine angle tumor.

Pituitary region: The most frequent primary tumor of the pituitary gland is the adenoma. The growth starts in the pituitary gland causing an enlargement and erosion of the walls and floor of the fossa shown on x-ray examination.

There occurs a deep-seated headache in the temporal or frontal regions from distention of the gland capsule and the diaphragma sellae. As the capsule and diaphragma give way the headache may disappear. Upward growth causes impairment of vision and primary optic atrophy from pressure on the mesial and inferior fibres of the optic chiasm producing a bitemporal hemianopsia in the upper quadrants. Lateral growth may cause an homonymous hemianopsia and hallucinations of smell and taste from involvement of the uncus of the temporal lobe. Adenomas are of the chromophobe and the chromophile varieties. The first is the most frequent type and produces symptoms of hypopituitarism manifested by adiposity, stunting of body growth failure of sexual development, libido asexualis in the male and amenorrhea in the female. In the chromophile type where the cells contain acidophile granules there are symptoms of hyperpituitarism manifested by giantism before and acromegaly after epiphyseal growth of the skeleton has been completed.

In children the most frequent tumor in this region is the supracellar cyst, or craniopharyngioma. This is a congenital tumor growing from misplaced epithelial cells in the developing pituitary stalk. This lesion frequently shows calcification in the supracellar region on x-ray examination, and it causes symptoms of a third ventricle tumor, increased intracranial pressure, and signs of hypopituitarism.

DIFFERENTIAL DIAGNOSIS

There is scarcely any disease of the brain which may not be simulated by brain tumor. The early symptoms are apt to be more confusing than after the general pressure signs have occurred. In the differential diagnosis the diseases most frequently confused with brain tumor will be considered.

Vascular lesions in the middle-aged and beyond are frequently found in the brain. The headache, dizziness, numbness, and paralysis may be suggestive of a brain tumor. Arteriosclerosis and vascular hypertension may be in favor of a vascular lesion but a brain tumor can not always be excluded without a ventriculography.

Encephalitis: There is a great tendency to diagnose atypical cerebral syndromes as encephalitis. In encephalitis there are fever and signs of infection preceding or accompanying the cerebral symptoms. The spinal fluid may show a slight increase in cell count of the lymphocytic variety with the fluid under normal or moderately increased pressure. Likewise a brain tumor may show an increase in cell count when located in the ventricle or bathed by the cerebrospinal fluid. A tumor may cause bleeding in the spinal fluid spaces giving the fluid a yellow tinge. A choked disc is not a frequent finding of encephalitis and its occurrence should always suggest a brain tumor.

Brain abscess will give the same clinical picture as brain tumor with the exception of a previous history of an infection which may be located in the sinuses, ears, a brain wound, the thoracic cavity or elsewhere in the body. After encapsulation of the abscess there is no fever nor leukocytosis. While both conditions are surgical the operative treatment is different and the diagnosis must be known in advance to obtain the best results.

Chronic subdural hematoma is caused by the formation of a clot in the subdural space due to the laceration of a cortical vein in a mild brain injury. The clot becomes encysted and gradually grows in size producing symptoms of a brain tumor weeks or months after the injury. Unless one obtains the history of trauma the true diagnosis may not be suspected until the brain has been explored at operation.

Syphilis of the meningo-vascular or paretic type may be confused with brain tumor, but since the Wassermann and Kahn reactions there has been little difficulty with the diagnosis. Gumma of the brain is rare and when it occurs it produces the same symptoms as a tumor. A patient may have a brain tumor in addition to syphilis and a positive Wassermann or Kahn does not rule it out.

Tuberculoma: Fifty years ago it was claimed that tuberculoma was one of the most frequent types of brain tumor. Since then tuberculosis has been on the decline and now tuberculoma of the brain is a rare finding. It is more apt to occur in childhood with a history of tuberculosis elsewhere in the body. It is important to make the diagnosis before operation if possible as the treatment consists of a palliative decompression and the usual hygienic measures used in the care of tuberculosis.

Metastatic tumors should always be considered in the diagnosis. A careful history and examination for tumors elsewhere in the body and in the lungs is important as well as the history of tumors removed at previous operations.

The diagnosis of epilepsy is sometimes made erroneously when there are generalized convulsions associated with brain tumor. Convulsions due to tumor may exist for years before the appearance of other symptoms.

Optic neuritis and sinus infection frequently come up in the differential diagnosis. Sinus infection is not a frequent cause of choked disc although the sinuses are often treated to cure a papilledema. An optic neuritis caused by a sinus infection shows a low grade swelling of the disc rarely over two diopters. As stated previously, when a choked disc is found, it is necessary to rule out a brain tumor before treating the patient for some other doubtful disease.

Acidosis is a diagnosis often made in childhood. Unexplained vomiting occurring early in the morning in a child should be indicative of a brain tumor and requires an eye ground examination.

Migraine and recurrent headaches are frequently associated with nausea and vomiting which may be suggestive of brain tumor. In favor of migraine is a family history of the condition and a negative neurological and eye ground examination. The latter does not rule out a tumor which may occur in a patient with typical migraine.

Where the differential diagnosis can not be made from the clinical history and examination it may be necessary to use other methods of diagnosis as ventriculography suggested by Dandy. It can be used with a reasonable degree of safety and accuracy. Without it an accurate diagnosis would be delayed and a misdirected operation done in many instances.

CONCLUSIONS

The presence of increased intracranial pressure and choked disc should always lead one to suspect a brain tumor. On the other hand the absence of choked disc does not rule it out since probably not more than half of the cases have this sign. The early symptoms are frequently manifested by small cerebral insults which may be easily confused with other conditions described in the text. In children the most frequent symptom is early morning vomiting with frequently a history of enlargement of the head. A careful history and neurological examination are necessary in the diagnosis which should always include investigation of the eye grounds and visual fields together with x-ray studies of the skull and occasionally ventriculography.

PROSTATISM: THE DETERMINING FACTORS IN ITS MANAGEMENT

With Special Reference to Prostatic Resorption*

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In the light of an increasing mass of evidence, it is now being conceded that prostatic disease in its early years is, in a substantial number of cases, amenable to less radical treatment than has heretofore been employed. This attitude on the part of urologists is propitious, for it is now evident that the early manifestations of prostatic disease are beginning to be recognized by the patient as something more than a natural accompaniment of advancing years.

Enlightenment on this subject appears to have reached the public through ethical channels since the onset of the resection era, and also to some extent in the past few years through unethical radio broadcasts. In consequence, it has been observed that patients seem to be presenting themselves for treatment earlier than in former years. Unfortunately, radical procedures seem to be all too fequently recommended by urologists in certain cases which logically belong to a group amenable to other measures.

At the time of my presentation of the resection operation[1] in 1926, I conceived it as admirably adapted to early prostatism, but even then recognized that other factors exist in the consideration of the prostatic case besides the immediate removal of the mechanical obstruction. At that time I stated: "In all cases of prostatic enlargement, except those frankly falling into the class of bars and contractures, there are present inflammation and edema, which when more than moderate in degree act as distinct contraindications to immediate resection." My conviction as to the validity of this statement has become stronger with added experience, and it is now my contention that measures directed to the control of prostatic disease are indicated in all cases before determining as to the final procedure.

The fact that the resection operation is now so easy of accomplishment in the majority of cases has caused several of its enthusiastic disciples to advise no preoperative treatment at all in patients showing only a few ounces of residual urine. By others it is claimed that the operation

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is immediately indicated in cases presenting vesical symptoms where little or no residual urine is present. Still others claim for the resection operation that it is the operation of choice in all cases, to the absolute exclusion of enucleation, barring only cases in which the resectoscope is impossible of introduction because of almost complete urethral atresia.

Statements of this nature do nothing constructive in establishing the indications for the various methods of treating this disease. While they may well express individual opinions, they cannot possibly include consideration of all the factors concerned in the best interest of the patient. That there are cases for which the enucleation operation is distinctly indicated is conceded by the majority of urologists. It is also obvious to many that in early prostatism many resections are performed where other less radical measures are indicated.

A less radical procedure is a form of treatment which I have called "Prostatic Resorption." This procedure, which I will later describe, has been of extreme value in early prostatism.

Resection is undoubtedly indicated in the bulk of all prostatic cases, but it must be conceded that it has been found inadequate in certain cases and too radical in others. The indications for enucleation which I include in this discussion will no doubt be considered by many as far from complete, but in an effort to establish a minimum standard, moot points must necessarily be excluded. Certain fundamental considerations in favor of enucleation in cases presenting extremely large glands, should receive our attention before entering more deeply into the subject.

It should be assumed that resection would not be essayed in instances where only an imperfect result could be obtained because of lobular extension anterior to the veru montanum or posteriorly, in too close proximity to the ureteral orifices. Prostatic calculi when embedded deeply in the gland also contraindicate resection. Diverticulum, or large calculi, causing a foul infected bladder suggests open operation, and in every instance should be a bar to resection. Persistent bleeding upon slight instrumentation during the preoperative treatment portends much waste of time for coagulation during a resection operation. A clean enucleation is to be preferred in cases continuing to present a purulent prostatic secretion despite adequate treatment. Here multiple discreet abscesses are present or a diffuse infective process act as contraindications to the resection operation.

In favor of resection, the reduced hazard to the patient in suitable cases is of primary importance. The shorter hospital stay, diminished expense and earlier convalescence are also very valid arguments. With regard to the element of risk it is often conceded by proponents of the enucleation operation that in much debilitated patients the resection operation is indicated for the purpose of establishing bladder drainage per urethram, even if perfect emptying is not accomplished. Thus it becomes obvious that the resection operation contains less of risk, and should be the operation of choice unless distinctly contraindicated.

In this discussion therefore, the general condition of the patient will be excluded, assuming that cystostomy or catheter drainage would be resorted to in cases not measuring up to certain standards as regards blood chemistry, renal function or cardiovascular state. The fact, however, is obvious that in border line cases, resection can be tempered to meet the conditions present. The quantity of intraspinal anesthetic can be gauged accordingly, and the amount of tissue resected gauged to permit of vesical functioning with the view of a subsequent resection if necessary.

As for the two-stage resection operation, much can be said in its favor. In the hands of fast operators much tissue can be removed in a single sitting, but for others, rather than continue the operation more than one hour the two-stage operation is preferable. On this point it has been generally conceded that the second operation is always more easy of accomplishment, and attended with less bleeding. The tissue is less spongy and far less vascular because of the destruction of the superficial capillaries. Another advantage of the two-step operation lies in the fact that the risk of incontinence is less and it is safer to remove too little tissue rather than too much. And it is often found that if the interval between operations is made two weeks instead of one, which is often the case, the subsidence of edema together with a retraction of the remaining portion of the gland, will permit of nearly perfect evacuation and obviate the necessity for the second sitting.

An argument in favor of the resection operation would not be complete were it not to contain the advantages in the amelioration of the

carcinoma case especially after deep x-ray therapy and the conspicuous results following the removal of a few sections in the fibrotic states.

PROSTATIC RESORPTION

Though reserved for the last in my discussion this subject is by no means of the least importance to the patient as it constitutes a simple prophylactic method, and contains less risk than resection in the treatment of early prostatism, and in a large percentage of these cases is all that is indicated.

My interest in this subject dates back to 1925, when I was engaged in my early experiments with under-water cutting with the first resection equipment. At that time the current at my disposal was only weakly capable of cutting under water, and it was found that unless the loop was made quite small it would frequently pass over the surface of the intruding tissue leaving in its wake a white dessicated line. Many unavailing efforts to adjust the current so as to cause it to cut, would thus be made upon the same patient at a single sitting.

Following these vain efforts our patients would frequently exhibit a mild febrile reaction, but it was observed that many of them would show an early improvement of their clinical manifestations, and upon subsequent cystoscopic examination present marked regressions in the size of their prostatic intrusions. Since that time it has been my practice in many early cases to administer this form of treatment with highly gratifying results.

These findings were reported by me in January, 1933,[2] at which time I also presented surface coagulation as a preparatory measure to the resection operation, and described[3] an "Ironing Electrode", for its accomplishment. This work was to have been presented at the annual meeting of the American Medical Association in June, 1933,[4] under the same title as the present communication. Kirwin[5] at about the same time made reference to "shrinkage" of the prostate by this "non destructive method", employing for the purpose the roller electrode to merely "heat" the tissue. Dr. Clinton K. Smith[6] has also contributed to the subject, and also observes that the febrile phase is more likely to be associated with the first resection. Thus it is found that when resection follows preliminary coagulation treatment the risk of infection is much reduced.

Examination a week or ten days after the coagulation reveals an ischemic, white mucous membrane replacing the vascular, edematous membrane usually present. Coincident with this change regression of the intruding masses occurs and vesicle function is restored. Frequently no further treatment is required.

It has been observed by many that the prostate is capable of shrinking after the removal of a few sections of its intruding parts, and it is this same resorption phenomenon which accompanies the superficial dessication process.

In dessication of the mucosa we have a means which may often suffice, but in the presence of bars and contractures probably no lasting benefit will result, and in more than moderate sized inflammatory enlargement of the middle and lateral lobes, examination after three or four weeks will yield information upon which one can easily decide as to the advisability of further measures.

Should resection be deemed necessary it will be found that the operation is easier of accomplishment because of the "firmness" of the tissue to be resected and because of the "smoother" convalescence insofar as infection and bleeding are concerned.

The "ironing electrode" to which I have previously referred is constructed of solid metal, convex in its lateral dimension and having a surface area of one-half square centimeter. This portion is mounted on a shaft so that it will fit the Stern Resectoscope taking the place of the loop.

The operation consists of engaging the protuberant masses in the fenestra and with single strokes of the electrode, make serial, linear striations about one centimeter apart. Thus the entire mucosa over the prostatic lobe is destroyed and the tissue underlying it is affected by the heat to a considerable depth. No rule as to the current strength can here be set down because of the variable factors present in machines of different makes. The coagulation current should be employed where it is available, and experiments upon meat will elicit information as to current strength and speed of the thrust. It is my custom to employ a current strength just capable of causing a faint pallor to the tissues as the electrode is moved slowly over it. The roller electrode has the disadvantage of making rather a sharp line upon which the current is concentrated. The current thus penetrates to a greater depth than when a flat surfaced electrode is employed. It is feasible to use the cutting loop

for this purpose, but great care must be exercised to adjust the current finely so that the loop will ride over the surface of the presenting tissue and not "dig" in.

Following this procedure the treatment is in all particulars the same as for resection. Catheter drainage is instituted employing one of small size, as there are no clots to be contended with; bleeding should be slight and of traumatic origin when present at all.

CONCLUSION

In determining upon the procedure to be followed in the management of prostatic patients, consideration should be given to certain factors which represent distinct indications for one of three procedures.

The enucleation operation is indicated in the presence of certain definite conditions, and should also be chosen when for any reason the resection operation cannot be carried out with a perfect technic in every detail.

The resection operation is in all probability indicated in the majority of prostatic cases. It is not applicable to all cases, and its contraindications should be established in order that it might find its rightful place in urologic surgery. Resection is frequently performed in cases of early prostatism where a less radical procedure will suffice.

Early prostatism, when treated as an infective process in which permanent tissue changes have not yet occurred, is amenable to various palliative measures. Resorption of moderate prostatic enlargements can be accomplished by the method herewith described. This procedure is all that is indicated in many cases of moderate middle and lateral lobe enlargements. The method is also a valuable preliminary measure to resection, facilitating the operation and robbing it of its unpleasant sequellae.

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THE IMPORTANCE OF VITAL STATISTICS TO THE CITIZEN*

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Last week I received a long letter from my aunt who is 70 years of age. The letter was for one purpose—to persuade me that I must be sure to obtain a certified copy of my birth certificate while she was alive and could swear to the necessary facts. The week before, she had made a trip to Preble County, Ohio, from Richmond, Indiana, at the request of my brother to obtain his birth certificate.

"Now I want you to get busy," she wrote me, "and get your birth certificate. Do not let it go. It is most important for you to have one. I know several old people who cannot prove their age because they do not have a birth certificate, and who are likely to lose the benefit of pensions because of that fact. If it is sent to me, I will see that it is signed properly."

At first I was amused at the thought that the Chief Statistician of the United States Division of Vital Statistics should be lectured by his aunt for not having his birth certificate on file, and then my thoughts turned to this audience of health workers whom I anticipated seeing on December 2. I wondered how many of you could claim to have on file in your State office, a birth certificate correct in every detail. I wondered how many of the State and city registrars might be negligent in this matter.

Several years ago I obtained a certified copy of my own birth certificate. Upon rescuing this from the dark recesses of my files, I found that the date of birth was incorrectly recorded, that my name was misspelled, and that my mother's name was incomplete. Moreover, the original birth certificate was filed more than a year after my birth and would probably be questioned if it ever should be introduced as evidence in a court of law. I am following my aunt's advice and obtaining clear-cut proof of the facts concerning my birth while relatives live who can testify under oath to these facts.

Birth and death are the two most important events in life—they are worth recording. A world without death is unthinkable. The remembrance of a motion picture comes to my mind, entitled "Death Takes a Holiday." In this

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fantastic picture Death neglects his duties for three days and treads the earth as a young man. No one on earth could die during those three days. On the second day as Death scanned through the morning paper, a frown crossed his face. The paper recounted the story of a despondent youth who had cast himself from the top of the Eiffel Tower and had miraculously lived. "Poor chap," said Death, "he wanted to die and I failed him."

A world without birth is unthinkable. In an amusing book by George Weston, entitled "His First Million Women," the earth comes under the influence of Comet X. Comet X possesses the peculiar power of reducing the fertility of all men to zero. Only one man in the world is free from the baleful influence of the mysterious comet. Fortunately, he is an American. International issues arise—the extinction of all the nations of the world is threatened—birth rates replace stock market quotations—armies march —conflict threatens—the world moves toward war. Statesmen barter for the rights of their respective countries in this one fertile male. However, no world dispute was ever solved more quickly than this one. Over night the influence of Comet X departed from the orbit of the earth and the young man found himself on the sidewalks once more, with exactly $7.84 in change in his pockets between himself and starvation.

In the near future it is probable that a world without complete registration of birth and death will also seem unthinkable. A certificate of birth has been aptly termed by a public health nurse in North Carolina as the "baby's first citizenship papers." If the certificate is recorded within ten days after birth, it becomes a document, the integrity of which is above question in the courts of law. If filed within ten days after birth, it is taken for granted by the courts that the filing was simply to record the birth, with no ulterior motive behind it; the case might not be so clear if the filing were delayed until the need for the certificate arose.

When an adult has a financial interest in the proof of his age, his parentage, or his place of birth, the sincerity of his motives is open to question. Dr. Thompson has recounted to me one instance where foreigners were smuggled into this country under the protection of a falsified birth certificate. The smugglers were finally apprehended because they used the same certificate repeatedly until it became tattered and dirty, thus arousing the suspicion of the immigration officers.

In 1926 when Will Rogers went abroad for the first time, he applied for a passport and was turned down because he could not produce any visible proof of his American citizenship. Provoked, he wrote an article in the Saturday Evening Post in which he made his famous statement, probably known to most of you: "When you see a boy running around with a pair of pants on, or without 'em for that matter, it is pretty good proof that he's been born."

There is apparently little doubt but that this statement of Will Rogers influenced the American public to a certain extent against birth registration. Early in 1934 a representative of the Bureau of the Census was authorized to contact Will Rogers in order to counteract this influence. His appointment took him to the polo field of the Santa Monica Ranch. Will Rogers was not aware that his original statement had hindered registration of birth. He wished to remedy the damage without retracting his word. "The original statement stands," he said. "When you see a boy running around with a pair of pants on, or without 'em for that matter, it is pretty good proof that he's been born—but it don't prove when, where at, nor who to."

A correctly recorded birth certificate carries the name of the child, date of birth, place of birth, legitimacy and sex of child, and the nationality, residence and birthplace of the parents. All of these factors are occasionally desirable, but in particular, proof of "when, where at, and who to" are the items usually desired.

The proof of place of birth is essential in order to establish citizenship in this country. Many a person has stopped off in Washington on his way to Europe in order to obtain a passport, only to find that the officials at the Department of State demand a birth certificate to prove that the individual was an American citizen and thus entitled to the protection of his country. Many a trip has been delayed while the traveler collects sufficient evidence to warrant officials issuing him a passport.

It is most embarrassing to be an American citizen outside the boundaries of your country, yet unable to prove that you are a citizen and have a right to enter. Americans who have been living in Canada are unable to return to the United States without a birth certificate or an affidavit to prove that they were born in this

country. Sometimes it costs a great deal of time and money to prove citizenship because of an absent certificate of birth. Parents can eliminate this sort of annoyance to their children in their after life by a simple inquiry of their physicians as to whether the baby was registered.

The name of the child must be correctly spelled on the original birth certificate; otherwise, it will be almost as difficult to prove the facts concerning birth as if no certificate had been obtained. Most states afford parents the opportunity to make these corrections as soon after the birth of the child as it is possible to do so. Without the name, the certificate is absolutely worthless except for statistical purposes. It has no value whatever to the person whose birth is registered, for it applies to no one except a nameless individual.

The Bureau of the Census furnishes to each State that desires it, an engraved Notification of Birth Registration, giving the name of the child, name of the father, maiden name of the mother, sex, date, and place of birth. Upon receipt of this notification, the parents can have a correction made before any occasion arises to demand the change. The state of Florida has its own form for Notification of Birth Registration, but many states depend upon the United States Division of Vital Statistics for their notification blanks. In an attempt to obtain a more attractive notification of birth—one which will be highly prized by the mother, the Bureau of the Census has had designed a new Notification of Birth Registration. This new notification was approved last week. Permission was secured from the Secretary of State to use the great United States seal in its design. I have with me a sample which I will circulate for your inspection.

Proof of age is the most usual demand made against the birth certificate. At the present time demands of this type arise, in part, from the need of children entering schools. A Notification of Birth Registration is sufficient proof for this purpose. Proof of age for the rights to marry, to engage in athletics, and to vote are demanded occasionally. The necessity for proof of age in order to obtain pensions is rapidly becoming a paramount need. With the passage of the Social Security legislation and the swing into prominence of the Townsend organization, old Census records are being worn out with constant searches for proof of age of individuals who have never had birth certificates. Many pathetic instances exist of old people who have forfeited their right to a pension because proof of age can not be obtained and no relatives remain alive who can testify concerning the facts of their birth.

The death certificate does not have as much value to the individual citizen as does the birth certificate. Most of the demands for a certified copy of the death certificate come in the first few months after death. These demands for the most part concern the settlement of estates and legal transactions.

Vital statistics are of indirect value to the private citizen because of their use by public health officers in the control of the preventable disease.

The success of the child health program depends to a certain extent on knowledge of the occurrence of births in order that the proper postnatal and infant care may be advised. The prompt delivery of notifications of birth registration to the mother by the public health nurse is an important part of the program of an active health unit, since it helps in securing proper registration of births and serves as a card of introduction to the family. Unless the birth is registered, the child is lost so far as the health officer is concerned. It cannot be visited, invited to attend clinics, or included in an immunization campaign. In the city of Chicago an elaborate follow-up system of monthly pamphlets stressing the importance of the breast feeding of infants has probably played a considerable role in lowering the city's infant death rate from 48 per 1,000 in 1934 to under 40 per 1,000 so far in 1935—a truly remarkable rate for a large city.

The public health worker depends upon vital statistics for the reports of deaths and mortality rates. How people live, and how they die are questions of the utmost importance to the health officer in your district. The total death rate for the United States in 1934 was 11 per 1,000; that for Florida was 12.9. But these are not the rates for your smaller health district. When any city or community experiences a mortality rate higher than the average, it should always be a matter of serious inquiry and concern of the health officer and of the citizens. The health official's responsibility includes a knowledge of the cause of death, the conditions influencing their occurrence, and the institution of preventive measures.

An intelligent plan of health work must be

based on an intimate knowledge of the occurrence of disease and causes of death. To make this possible requires complete and accurate registration of deaths. Consequently, this is one of the responsibilities which the health officer shares with the Department of Vital Statistics. He is daily associated with the physicians, midwives, and others who are required to report births, sickness, and deaths. Local registrars are officials of the State Department of Health, and as such, they are a part of the official health family in your district. Treat them as such, and you will have their full cooperation not only in matters relating to vital statistics, but in the entire public health program of your community.

The quality of public health work depends to a considerable degree upon the accuracy of the State registrar in his duties. He must check the efficiency of the work of the local registrars by reviewing each certificate received, for completeness and accuracy. In past years the activity of the central office was practically confined to this work. Now, an up-to-date Bureau keeps the State and district health officers informed of health conditions throughout the State and its different subdivisions by weekly or monthly tabulations. It is important that health workers have this information, especially the prevalence of communicable diseases in adjoining counties. He can measure the effectiveness of public health activities and advise of threatening epidemics. He can furnish detailed analyses of data concerning the state and the county.

The State registrar is the only source for one very important kind of information—that on residence. Birth and death rates uncorrected for residence mean little in a county with a large hospital or in one which depends for hospital service on an adjoining county or city.

A crude tuberculosis death rate is unreliable. For an intelligent knowledge of the tuberculosis problem, information on all residents of your county who have or who die of this disease is needed. Without this data many contact cases as well as active cases of tuberculosis will be missed.

Vital statistics are of indirect value to the private citizen because of their social use as statistical tabulations. Some of these tabulations are made in the offices of the State and city registrars of vital statistics; many of them are produced by the United States Division of Vital Statistics in the Bureau of the Census.

The manner of distribution of national funds available for child welfare work is an example of the use of such tabulations. The Federal funds for child welfare work are distributed according to the percentage of births in the various states. One state last year lost its fair proportion of these funds simply because of the negligence of one registrar who delayed mailing a large group of birth certificates until it was too late for them to be counted as a part of 1934 statistics.

In these days of declining birth rates it is an important factor in the civic welfare of any city to be able to claim as high a birth rate as possible and as low a death rate. An increasing population is more than a matter of civic pride. Following the 1880 Census, the birth rate for this country was estimated at 36 per 1,000 population; last year the rate was 17.1. In 1924 when Florida was admitted to the birth registration area, the birth rate in this state was 21.8; in 1934 it was 17.0.

There is no one element of security which affects the average citizen so universally as the use of life insurance protection for his dependents. Tabulations of the numbers of people dying according to their age, sex, and race is the information used by life insurance companies in adjusting their rates and premiums. Some of the companies also use the statistics of cause of death as a basis for annuity premiums.

Above all other social uses of vital statistics is the part they play in the estimation of the population base of the community in which the citizen lives. Most social values are reduced for sake of comparison to the number or value per unit of population. Birth and death rates are the number of births or deaths per 1,000. Sickness rates are stated per unit of population. Most economic measures of the community in which you live are reduced to the population base. Tax rates in mills per person, income and wealth per person or per family, per capita consumption of all types of food and goods, public utility rates, and many other vital facts which affect the daily life of the ordinary citizen depend upon population estimates.

The function of measuring population is the responsibility of the Census Bureau. The fifth census was taken in the United States in 1830. The total population of the United States was somewhat under 13 million; in 1930 it was almost

123 million—an increase of ten people for every one who lived in the country 100 years ago. In Florida there was an increase of 42 persons for every one who lived in this state 100 years ago.

Until very recently, estimates of intercensal populations were based on the assumption that the population increased at an even rate each year. During the last few years, changes in population in the different subdivisions of the United States have been so great that this method is now considered unsatisfactory. Efforts were made to obtain a census for 1935, which, if approved, would have solved the problem by shortening the period between censuses to five years. The project did not receive official approval. Consequently, on September 21, 1935, a conference was called by the Population Association of America, in cooperation with the United States Bureau of the Census, to consider the whole problem of making annual estimates of population. The recommendations of this committee were approved with minor modifications by the Advisory Committee of the Bureau of the Census on November 23 as follows:

IT IS RECOMMENDED:

1. That insofar as available information will permit satisfactory estimates:
   (a) The Bureau of the Census continue to accept the responsibility for making population estimates;
   (b) Estimates be made for cities having 10,000 or more inhabitants at the 1930 census;
   (c) Estimates be made for counties or for groups of counties;
   (d) Estimates be made for the rural population of States and for the population of cities of 2,500 to 10,000 in each State as a group.
2. That in making these estimates, the Bureau of the Census avail itself of all useful material, whether or not of its own origination.
3. That the methods for constructing the estimates shall be determined by the Bureau of the Census; and
   That in publication the Bureau describe the method or methods which have been employed, and indicate the reliability to be expected for the population estimates.
4. That the Bureau of the Census be provided with adequate facilities for making short-term population estimates.

The Bureau of the Census accepted these recommendations and assigned the responsibility for making population estimates to Dr. Leon E. Truesdell, Population Division. Tabulations of births and deaths in cities and states, together with school attendance records, will be the principal basis for these new estimates.

In addition to the use of vital statistics in the every-day life of the citizen—as a documentation of vital facts in his life, as an aid to public health activities which guard his physical welfare, and as a social means of measuring the forces which affect various phases of his economic life—vital statistics offers a fascinating field of scientific investigation, the pursuit of which will lead eventually to the determination of fundamental laws concerning the vitality of the race, the causes of death, and the fertility of the race. The impact of civilization upon the peoples of the world, the influence of season, disease, occupation, and genetics are enticing subjects latent with potential benefits. The science of vital statistics is interwoven with the beginning and end of life. It touches human welfare at every point through the span of life. It will serve your children and your children's children. It is a subject worthy of the interest, the approval, and the aid of every citizen. It is an autobiography to which each of you contributes and which, in the aggregate, forms the autobiography of this community, this state, and this entire nation.

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DR. W. A. McPHAUL APPOINTED STATE HEALTH OFFICER

Honorable David Sholtz, Governor of Florida, upon unanimous recommendation of the State Board of Health, has announced the appointment of Dr. W. A. McPhaul as State Health Officer. Dr. McPhaul is licensed to practice medicine in Florida and for the past four years, has been Director of the Escambia County Health Unit which was the third of the units in Florida to organize on a full-time basis for health.

Dr. McPhaul, who is a native of Robeson County, North Carolina, attended University of the South, Sewanee, Tennessee, and is a graduate of the University of Nashville (now a part of the University of Tennessee) where he received his M.D. degree in 1905. He was part-time health officer for Robeson County, North Caroline, from 1907 to 1911. In 1911, Dr. McPhaul was a member of the House of Representatives of the North Carolina legislature and served as chairman of the Committee on Public Health. Dr. McPhaul served as whole-time health officer for Robeson County, North Carolina, 1916-1918. He served as Director of Rural Sanitation for the State Board of Health of Alabama in 1919 and health officer for the city of Montgomery, Alabama, in 1920.

During the year 1926, Dr. McPhaul took post-graduate work in Tropical Medicine at Tulane University. He served as health officer of Charlotte, North Carolina, from 1921 to 1931.

CORRESPONDENCE

Dr. J. Knox Simpson, chairman of the Committee on Boat Trip, has requested the editor to reproduce the following letter. This letter has been mailed to each member of the Association. The members of the Committee on Boat Trip are J. Knox Simpson, Jacksonville, chairman; Frank D. Gray, Orlando; Walter C. Payne, Pensacola; Homer L. Pearson, Miami, and Joseph W. Taylor, Tampa.

December 28, 1935.

To Members of Florida Medical Association:

Your Committee on Boat Trip for the next meeting of the Florida Medical Association begs to submit for your consideration the following information:

1. The dates of the meeting, as selected by the Executive Committee of the Association, are April 27, 28, and 29, 1936.
2. The meeting is to be held aboard the S.S. "Florida" of the P. & O. Steamship Company, sailing from Miami at 8:00 a. m., April 27 and landing in Miami at noon of April 29. Breakfast on the sailing date and luncheon on the landing date are included in the boat fare.
3. The schedule of events on the trip are as follows: First day out—morning hours, 8:30 to 12:00, reserved for meeting of Railway Surgeons and the various group meetings; afternoon hours, general session and scientific program; evening hours, meeting of House of Delegates. Second day out—8:30 to 12:00, scientific program and general session; 1:00 o'clock, dock at Havana; afternoon, sightseeing trips and golf; evening meal may be had aboard ship without expense or may be had in Havana at your own expense. The ship will leave Havana at midnight of the day of its arrival. Third day out—8:30 a. m. to 12:00, scientific program and general session, ship docking at Miami at noon of the third day. You will observe that the same amount of time will be allotted to scientific programs as is done in meetings ashore, giving ample opportunity for scientific and business sessions and we feel that there will be a better attendance at all sessions than on land because of the confinement of the crowd to a small area.
4. The boat will cruise around in the waters adjacent to the Bahama Islands between the time of sailing and time of landing at Havana on the second day out.

5. The exact expense is $35.00, Miami to Miami. This includes all expenses aboard ship and in Havana, and includes a four-hour tour around the city in large comfortable touring cars with certain interesting points visited, one of which is a typical Cuban farm where a cock-fight will be held. Those who play golf will have their trip to and from the golf course and their greens fees included in the ticket. The boat will leave Havana on the return trip about midnight.
6. Those who are entitled to go on the trip are the members of the Florida Medical Association and their immediate families, plus a certain number of exhibitors.
7. The Executive Committee of the State Association, at a meeting held recently in Jacksonville, made the following rulings:
   (a) That a deposit of $10.00 per passenger should accompany all reservations, check being made payable to the P. & O. Steamship Company and mailed to their office, Florida National Bank Bldg., Jacksonville, at least sixty days prior to the meeting which would make February 27 the last day for reservations to be made.
   (b) That assignment of space aboard ship shall be in the order in which reservations are received.
   (c) That each member of the Association shall be notified in writing thirty days in advance of the meeting in case the boat trip is called off and the meeting is to be held in Miami instead.
8. All advance indications are that more applications for passage will be received than can be accommodated. Reservations should, therefore, be made as early as possible. A maximum of 475 can be comfortably accommodated.
9. A return card is being enclosed. Please fill it in and return it to the Committee on Boat Trip at the earliest possible time so that we can proceed with our plans without delay.

Respectfully submitted,
(Signed) J. Knox Simpson, M.D.,
Chairman Committee on Boat Trip.

N.B.—Your attention is especially called to the fact that during the forty years of records kept by the P. & O. Steamship Company of the weather in these waters, there has never been a hurricane or a storm of any consequence between December 1 and July 1 of any year.

PRE-CONVENTION MEETING

President Bryans has announced the Pre-Convention meeting date as Sunday, February 23. The meeting will be held at the Carling Hotel, Jacksonville. All members of the Association are invited to meet at 1:00 p. m. for luncheon at which time the Councilors' reports will be read and announcements made by the chairmen of the various committees. The price of the luncheon will be 75c.

Committee chairmen are requested to have their committee meetings Sunday forenoon preceding the main session. Councilors are asked to have their reports ready to read at the 1:00 o'clock meeting. Councilors who find it impossible to attend should mail in their councilor reports to be read by the secretary.

STATE NEWS ITEMS

Drs. O. O. Feaster, St. Petersburg, H. B. McEuen, Jacksonville, and Gerard Raap of Miami were among those in attendance at the meeting of the Radiological Society of North America, which was held in Detroit, December 2 to 6.

* * *

Dr. and Mrs. P. H. Guinand of Clearwater announce the birth of a daughter, Alice Bratton, at the Morton Plant Hospital, December 11.

* * *

Dr. R. H. McGinnis of Jacksonville recently resigned as chief of the department of medicine at the Duval County Hospital after 35 years of service. In recognition of his long and excellent service to the hospital and to the community, the hospital board designated Dr. McGinnis as chief emeritus of the department of medicine, a new and unprecedented honor in the history of the hospital.

* * *

Dr. T. H. Bates of Lake City was signally honored recently by the award of the American Legion's distinguished service medal for 1935. The citation was in part as follows: "For services above and beyond the usual call of duty of citizenship and in recognition of his years of service in the medical profession and other public endeavors". Friends of Doctor Bates feel elated over the 1935 selection and the committee is being complimented on the choice.

* * *

A reproduction of a letter to all members of the Association from the Chairman of the Committee on Boat Trip will be found on page 315 of this Journal. Did you see the advertisement on the front page?

The Association's Committee on Public Relations held a meeting in Orlando, Wednesday, December 4, and the following report has been received from the chairman, Dr. J. Ralston Wells:

"The following subjects were discussed and transactions decided upon: The broadcasting from station WRUF every Sunday evening, 6:00-6:15 throughout the year was approved; the appreciation of the Committee for the broadcasting privileges was warmly expressed as was also the cooperation of the various physicians in presenting papers. The Florida Hospital Association will be invited to present several talks on Medical Economics from their standpoint. A symposium on Medical Economics will be presented as follows:

March 1—Introduction to Medical Economics I.
March 8—Introduction to Medical Economics II.
March 15—Cost of Medical Education.
March 22—Medical Relation to Workman's Compensation.
March 29—Health Insurance.
April 5—Defects in Medical Insurance.
April 12—Contract Practice.
April 19—Health Insurance in England.
April 26—Health Insurance in Various Parts of the World.
May 3—A Synopsis and Critical Analysis of Sickness Insurance and Cost of Medical Care.

"The names of the speakers taking the various subjects will be published at a later date. As each subject is presented on each Sunday, the same talk will be put over as many State radio stations as is possible during the ensuing week. These talks will then be distributed to each state member either in mimeographic form or by special attention in the Journal.

"The Committee understands that the Committee on Legislation will have several revised bills to be presented at the next Legislature, and that it will be asked to aid in disseminating these proposed bills, contacting the various prospective legislators before they are elected to ascertain their position toward organized medicine. This should have very considerable to do in electing or defeating the various candidates according to the views they hold.

"Thanks were expressed to the A. M. A. for their cooperation through Doctor Leland, for the aid in supplying printed pamphlets and material from which our radio talks can be based."

The American Board of Ophthalmology will hold its 1936 examinations in Kansas City, May 11 at the time of meeting of the A. M. A., and in New York City in October at the time of the meeting of the American Academy. All applications and case reports must be filed at least sixty days before date of examination. For information, syllabuses and application forms, write to Dr. Thomas D. Allen, Asst. Secy., 122 So. Michigan Ave., Chicago.

* * *

Dr. Louie Limbaugh of Jacksonville has been appointed chief of the department of medicine at the Duval County Hospital to succeed Dr. R H. McGinnis, resigned.

* * *

Seventeen component societies of the Association stand 100% paid in dues for 1935 at the beginning of this year. They are: Broward, Columbia, Dade, DeSoto-Hardee-Highlands, Escambia, Lee, Madison, Marion, Monroe, Orange, Palm Beach, Pasco-Hernando-Citrus, Polk, St. Johns, Seminole, Sumter and Taylor. Several other societies have only one or two members in arrears and will no doubt join the 100% group very soon.

PAUL COLSON PERRY

Dr. Paul Colson Perry was born at Lake City, Florida, January 4, 1875, the son of J. W. and Louise Osteen Perry.

Dr. Perry received his education at Columbia College (now the University of Florida) at Lake City and the College of Physicians and Surgeons (now University of Maryland) at Baltimore, Maryland. Following his graduation from the latter institution in 1898, he came to Jacksonville and practiced his profession there until in 1926. During this time, he served on the staff of St. Luke's Hospital, the Duval County Hospital and St. Vincent's Hospital. Doctor Perry and the late Dr. John E. Boyd owned and operated the DeSoto Sanitarium which was later acquired by the Sisters of Charity.

Dr. Perry was for many years prominent in the work of the Florida Medical Association and served as its president in 1913. He was a member of the American Medical Association and the Surgeons' Club.

Dr. Perry died June 5, 1935, at St. Elizabeth's Hospital, Richmond, Virginia.

The Seventh Annual Assembly of the Southeastern Surgical Congress will be held in New Orleans, March 9-10-11, 1936, at the Roosevelt Hotel. The following surgeons have accepted places on the program: Dr. Arthur Hertzler, Halstead, Kan., Dr. Chevalier Jackson, Philadelphia, Dr. Francis E. Lejeune, New Orleans, Dr. Arthur W. Allen, Boston, Dr. John F. Erdmann, New York City, Dr. Jennings Litzenberg, Minneapolis, Dr. Joseph E. King, New York City, Dr. Fred Rankin, Lexington, Dr. C. C. Howard, Glasgow, Ky., Dr. George W. Crile, Cleveland, Dr. Garnett W. Quillian, Atlanta, Dr. Paul Flothow, Seattle, Wash., Dr. Alan C. Woods, Baltimore, Dr. Virgil S. Counseller, Mayo Clinic, Dr. Alfred A. Strauss, Chicago, Dr. W. D. Haggard, Nashville, Dr. Roger G. Doughty, Columbia, S. C., Dr. Thomas E. Cormody, Denver, Dr. Charles O. Bates, Greenville, S. C., Dr. Guy Caldwell, Shreveport, Dr. Gerry Holden, Jacksonville, Dr. Emmerich von Haam, New Orleans, Dr. Roger Anderson, Seattle, Wash., Dr. A. Street, Vicksburg, Miss., Dr. James S. McLester, Birmingham, Dr. Edgar Fincher, Jr., Atlanta. There will be others.

* * *

Through the cooperation of President Herbert L. Bryans, an old volume of the Florida Medical Association proceedings, dated 1886, has been located. Through information contained in this volume, four additions and one correction were made to the Association's list of past presidents. From the proceedings as published in 1886, the records show that in 1884, Dr. John P. Wahl of Tampa was president; 1885, Dr. N. D. Phillips, Gainesville; 1886, Dr. Joseph Y. Porter, Key West; 1887, Dr. J. W. Hicks, Orlando, and in 1888, Dr. R. A. Lancaster, Gainesville. This makes the list of past presidents complete beginning with 1888.

* * *

COMPONENT COUNTY SOCIETIES

COLUMBIA COUNTY MEDICAL SOCIETY

At its annual meeting, held December 11, the Columbia County Medical Society elected the following officers to serve for the ensuing year:
President—L. M. Anderson.
Vice-President—R. B. Harkness.
Sec'y-Treasurer—T. H. Bates.
Delegate—R. B. Harkness.
Alternate—W. S. Nichols.

DADE COUNTY MEDICAL SOCIETY

THE DADE COUNTY MEDICAL SOCIETY, THE LARGEST COMPONENT PART OF THE ASSOCIATION, HAS REPORTED 100% DUES PAID FOR 1935. WITH A MEMBERSHIP OF 210, THIS SOCIETY HOLDS AN ENVIABLE RECORD. THIS IS THE THIRD SUCCESSIVE YEAR THIS SOCIETY STANDS 100% PAID.

* * *

DUVAL COUNTY MEDICAL SOCIETY

At the meeting of the Duval County Medical Society, held in the Mayflower Hotel, Jacksonville, January 7, the following scientific program was presented:

"Carcinoma of the Larynx, a follow through on a case including the post mortem findings." (With lantern slides and color film demonstration), H. B. McEuen.

"Pyelitis in Pregnancy" (with lantern slides), I. J. Strumpf.

Following the scientific session, a business meeting was held at which committee reports were heard.

The following resolution was adopted:

"WHEREAS, Doctor Henry Hanson, a member of the Duval County Medical Society, and until recently State Health Officer of the State of Florida, has been relieved of his duties here, and

"WHEREAS, Doctor Hanson's contributions to the public weal have proceeded far beyond the bounds set by the routine of his office and

"WHEREAS, during his residence in Florida he has been instrumental in establishing in this state several outstanding health projects, notable among which are:

1. The establishment of the joint laboratory of the Rockefeller Foundation and the State Board of Health for Malaria research, situated at Tallahassee,

2. Establishment of a station for malaria investigation, work which is carried on under the joint direction of the United States Public Health Service and the Florida State Board of Health,

3. Organization of the Florida Public Health Association, Incorporated, which has developed a program said to be second to none in this coun-

try; at whose annual meetings appear leading figures in the field of public health,

4. The building up of a public health and medical library at the State Board of Health Building in Jacksonville, Florida, and

"WHEREAS, the activities of Doctor Hanson since his medical education have been as follows:

"Graduating from the Johns Hopkins Medical School in 1908, then serving an internship at Milwaukee General Hospital in 1909. Dr. Hanson came to Jacksonville as director of the State Board of Health laboratory, in which capacity he served until the entry of the United States into the World War in 1917. Entering the United States Army with the rank of Captain in the Medical Corps he was promoted to that of Major and was made general inspector of sanitation in the Panama Canal Zone. Following the war he was made chief health officer in Peru and served through and was in charge of yellow fever control work. Contracting yellow fever himself while fighting to prevent its spread he became so ill that it was once reported that he had died.

"In 1922 Doctor Hanson was detailed by the Rockefeller Foundation to Colombia, South America, to investigate the epidemiology of yellow fever there.

"From 1925 to 1927 he was a member of the special staff of the Rockefeller Foundation and was on duty with its West African yellow fever commission, following which he returned to the United States and became a district health officer for the State of Florida, from which post he was appointed as State Health Officer in 1929; and

"WHEREAS, the work accomplished in behalf of the citizens of the State of Florida during Doctor Hanson's period of office having redounded immeasurably to their welfare and that of posterity, as well as gaining international recognition for this scientist who was closely associated with such pioneers in tropical medicine and public health endeavor as Doctor Carter, Gen. Gorgas, Doctor Noguchi and Dr. White, and

"WHEREAS, the priceless gift of character and fellowship that was his will be ever sorely missed from our midst,

'NOW, THEREFORE BE IT RESOLVED that the Duval Medical Society in regular session express its deep regret upon the loss from its membership of Doctor Henry Hanson, that this resolution be spread upon the minutes of this Society, and that a copy of the same be forwarded to Dr. Hanson in beloved token of our deep appreciation for him and his work.

Committee on Fraternal Relations, D. C. M. S.
(Signed) L. Y. DYRENFORTH, M.D.,
Chairman."

ESCAMBIA COUNTY MEDICAL SOCIETY

At the December meeting of the Escambia County Medical Society, the following officers were elected for 1936:

President—A. M. Ames, Pensacola.
Vice-President—J. I. Turberville, Century.
Sec'y-Treasurer—J. M. Hoffman, Pensacola.

LEE COUNTY MEDICAL SOCIETY

Election of officers was held by the Lee County Medical Society at its meeting held December 20. The following were chosen to serve for 1936:

President—W. H. Grace, Ft. Myers.
Vice-President—R. D. Newton, Ft. Myers.
Sec'y-Treasurer—H. Quillian Jones, Ft. Myers.
Delegate—Ernest Bostelman, Ft. Myers.
Alternate—W. H. Grace, Ft. Myers.
Censors—H. J. Stipe, Fred Bartleson and B. Whisnant.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

At a meeting of the Pasco-Hernando-Citrus County Medical Society, held at Brooksville with Dr. A. B. Cannon of Lacoochee as host, election of officers was held, which resulted as follows:

President—R. D. Sistrunk, Dade City.
First Vice-Pres.—S. C. Harvard, Brooksville.
Second Vice-Pres.—P. J. Hudson, Crystal River.
Sec'y-Treas.—J. J. Bourke, Dade City.
Delegate—S. C. Harvard, Brooksville.
Alternate—A. C. Coogler, Brooksville.

ST. JOHNS COUNTY MEDICAL SOCIETY

At a meeting of the St. Johns County Medical Society held December 17, 1935, the following officers were elected to serve for 1936:

President—Herbert E. White.
Vice-President—George W. Potter.
Secretary—R. D. Harris.
Treasurer—A. Clark Walkup.
Delegate—V. A. Lockwood.
Alternate—Herbert E. White.
Censors—G. W. Potter, Chairman; H. E. White, C. C. Grace.

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Dear Co-Workers:

After careful consideration of all work at hand by the Advisory Board and State officers of the Woman's Auxiliary to the Florida Medical Association, recognizing that a few things well done are more commendable than many poorly carried out, I am giving you, as President of the County Woman's Auxiliary the following Charge for the year's work:

1. Give as wide publicity as possible to the American Medical Association broadcast of medical emergencies on Tuesday at 5 o'clock p. m. over the National Broadcasting Company, and as has already been requested by your State Program Chairman, secure the program for your station in preference to a local broadcast if possible.
2. Make plans for the use of the study envelope concerning "Healthy Hearts" at one meeting this winter.
3. Read to as many organizations as possible the three minute talk, "The Necessity of Health Cards for Household Servants."
4. Prepare an exhibit for the State Medical Association Meeting in May.
5. Make every effort to fulfill your Hygeia quota.

   Added Suggestion: The National University Extension Association has chosen "Medical Service at Public Expense," for debate for 1935 and 1936. We hope that the Auxiliary members will endeavor to assist debaters from their own High Schools to secure authentic literature on this subject and an understanding of the attitude of the medical profession.

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We are particularly anxious that all auxiliaries carry out a uniform program in part. There are many other forms of activities for those of you interested in other fields about which your program chairman will be glad to advise.

With best wishes for a successful year, I am,

Sincerely yours,

(Mrs. E. W.) Clara Veal, President,

Florida State Medical Auxiliary.

Southern Medical Auxiliary

The Woman's Auxiliary to the Southern Medical Association held their twelfth annual meeting in St. Louis, Missouri, November 19-22, 1935, with headquarters at the Jefferson Hotel. The Woman's Auxiliary to the St. Louis Medical Society acted as hostess to all the visiting ladies.

The Executive Board met Wednesday, November 20th, at 9:30 p. m. with the president, Mrs. J. Bonar White, presiding. The past year's work was reported and discussed. This meeting was followed by a luncheon and open meeting of the Southern Auxiliary in the beautiful Crystal Room of the Jefferson Hotel. Among the distinguished guests and speakers introduced were Dr. Marshall Taylor, president of the Southern Medical Association; Dr. Seale Harris, chairman of the Advisory Board; Mrs. Rogers N. Herbert, president of the Woman's Auxiliary to the American Medical Association and many others. Following the luncheon a Round Table Conference was held at which time several very interesting and inspiring short talks were given by four chairmen of the National Auxiliary. The work of organization was by Mrs. J. Bonar White; program, Mrs. V. E. Holcombe; Hygeia, Mrs. James D. Lester; and history, Mrs. William Hibbitts.

On Wednesday from 4:00 to 6:00 p. m. the Woman's Club of St. Louis University School of Medicine entertained with a tea at the St. Mary's Hospital Nurses' Home, after which a style show was featured with many of the doctor's wives and daughters modeling.

The general business session of the Auxiliary was held on Thursday, November 21st, at 9:30 a. m. Reports from officers, committee chairmen and state presidents were read. Words are inadequate to describe the inspiration received from this meeting; the graciousness of the president, Mrs. J. Bonar White, the beautiful memorial service in which our own deceased members, Mrs. Chalker of Ocala and Mrs. Shaler Richardson of Jacksonville were remem-

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bered, the talks by many past presidents and the founders of the Southern and National Auxiliaries and the report of the president, Mrs. J. Bonar White showing an increase in membership of more than eight hundred this year.

Honorable mention was given Mrs. H. Marshall Taylor, wife of the immediate past president of the Southern Medical Association. At her suggestion a special lounge for ladies was provided on the lobby floor of the Jefferson Hotel. This room was for "the waiting wives" and other visiting ladies. It was decorated exclusively by Mrs. Taylor with a profusion of moss, palms and native Florida tropical growth. Mrs. Taylor received informally all the visiting ladies on Wednesday morning from 10:30 to 12:30 and served cold orange juice and dasheen chips and gave each visitor a small green coconut as a souvenir from Florida. Mrs. Taylor was assisted in this gesture of true southern hospitality by the following Florida ladies: Mrs. Edward Jelks, Mrs. Kenneth Morris, Mrs. Louie Limbaugh, Mrs. R. R. Killinger, Mrs. Clayton Royce and Mrs. E. W. Veal.

ORANGE COUNTY AUXILIARY

The members of the Woman's Auxiliary to the Orange County Medical Society met for luncheon at the Colonial Court Hotel in November. Two new members, Mrs. Taylor Gwathmey and Mrs. R. P. Henderson were presented.

The principal speaker and guest of honor was Mrs. Wilburn Lassiter, of Gainesville, a past president of the State Medical Auxiliary for two years.

There was no meeting of the local auxiliary in December, because of the holidays. The next meeting will be the fourth Tuesday in January.

POLK COUNTY AUXILIARY

The Woman's Auxiliary to the Polk County Medical Society met at the home of Dr. and Mrs. R. L. Hughes, in Bartow, Wednesday evening, December 11th, at 7 o'clock.

A delicious turkey dinner was served. Tables were beautifully arranged with place cards and favors of the Christmas motif. A brief business session followed. The minutes of the last meeting were read and approved. Mrs. R. L. Cline was appointed Hygeia chairman, and Mrs. J. W. Vaughn, Press and Publicity chairman. The Auxiliary was glad to welcome Mrs. B. J. Bond of Winter Haven, as a new member, and Mrs. J. W. Pamplin, daughter of Dr. and Mrs. R. L. Hughes, as a guest at this meeting. A number



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of games, limericks and stunts were provided by Mrs. E. R. McMurray. The social hour was enjoyed by all. The next meeting will be held in Winter Haven. Members present from Bartow were: Mrs. R. L. Hughes, Mrs. C. H. Murphy, Mrs. J. G. Gilchrist, Mrs. J. L. Hargrove, Mrs. W. F. Peacock, and Mrs. E. R. McMurray; from Pierce, Mrs. V. H. Ragsdale; Winter Haven, Mrs. W. T. Simpson and Mrs. B. J. Bond; Ft. Meade, Mrs. G. H. Carefoot; Brewster, Mrs. E. A. Harris; and Lakeland, Mrs. L. B. Nicholson, Mrs. F. S. Smith, Mrs. Joe M. Bosworth, Mrs. John F. Wilson, Mrs. R. L. Cline, Mrs. W. L. Tillis and Mrs. J. W. Vaughn.

PINELLAS COUNTY AUXILIARY

A meeting of the Auxiliary to the Pinellas County Medical Society was held at the Concord Hotel at 12 o'clock noon, November 25, in the form of a luncheon and was attended by 19 members and 5 guests.

The question of keeping a scrapbook was discussed. The Duval County Auxiliary's scrapbook was exhibited and received very favorable comment. It was decided upon at this meeting that a contribution be made to the Empty Stocking Fund as in past years. A motion was made and seconded that the Auxiliary entertain the members of the Pinellas County Medical Society at a dinner and some form of entertainment at a date to be decided later.

After the business meeting a musical program was presented by Dr. Trainor (a retired physician from Massachusetts), accompanied at the piano by the president, Mrs. R. K. O'Brien.

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Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245
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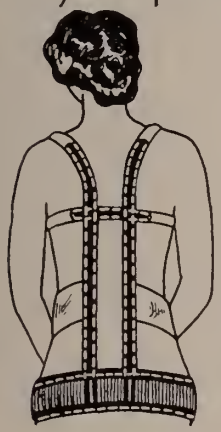
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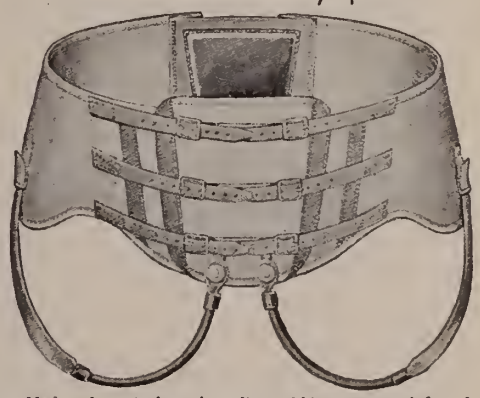
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Dextrose in Malnutrition

The "Proceedings of the Society for Experimental Biology and Medicine," 1935, 32, 1463-1464, contains an article on "Dextrose in Malnutrition," by Genevieve Stearns, Ruth Catherwood and Abraham Kantrow from the Department of Pediatrics, State University of Iowa.

The work connected with the research outlined in this article was done under a fellowship offered by the Corn Industries Research Foundation. It is one of a series of projects which may throw new light on some phases of carbohydrate metabolism.

The Foundation is fortunate in having the cooperation of Dr. P. C. Jeans, who directed the study referred to above, and of Dr. F. W. Schultz and Dr. A. J. Carlson of the University of Chicago, Dr. John R. Murlin of the University of Rochester, Dr. J. H. Means and Dr. L. J. Henderson of the Harvard Medical School, Dr. Henry G. Sherman of Columbia University, as well as other outstanding men.

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The Borden Digest

SUMMARY OF DECEMBER ISSUE

Beta lactose and sodium citrate proved to be the best prelacteal food for reducing loss of weight in new-born infants, according to the extensive clinical study reported in Abstract No. 121.

Dietary principles for infants during the first three months of life are set forth in the paper which is the basis of Abstract No. 120. Evaporated and dried milks receive high commendation in this article.

Powdered whole lactic acid milk formulas were successful in preventing cases of summer diarrhea in about 400 malnourished infants, as shown in the study outlined in Abstract No. 122.

Lactic acid milk formulas prepared from evaporated milk are recommended, in the article reviewed in Abstract No. 123, as particularly valuable in preventing bacillary dysentery in infants.

Acidophilus therapy receives favorable comment in the editorial mentioned in Abstract No. 124. To achieve the best results, continuous large amounts of the L. acidophilus must be supplemented with lactose and dextrin in the diet.

Pasteurization of certified milk is stated in Abstract No. 125 to be a most significant forward step.

The lack of vitamin D in common foods and the need of providing it routinely in the diet are discussed in the editorial summarized in Abstract No. 127, and the article epitomized in Abstract No. 126. Further experiments showing that cholesterol contains the provitamin D are reported in Abstract No. 128.

A recent new book purporting to treat the subject of diet is appropriately reviewed in Abstract No. 129.

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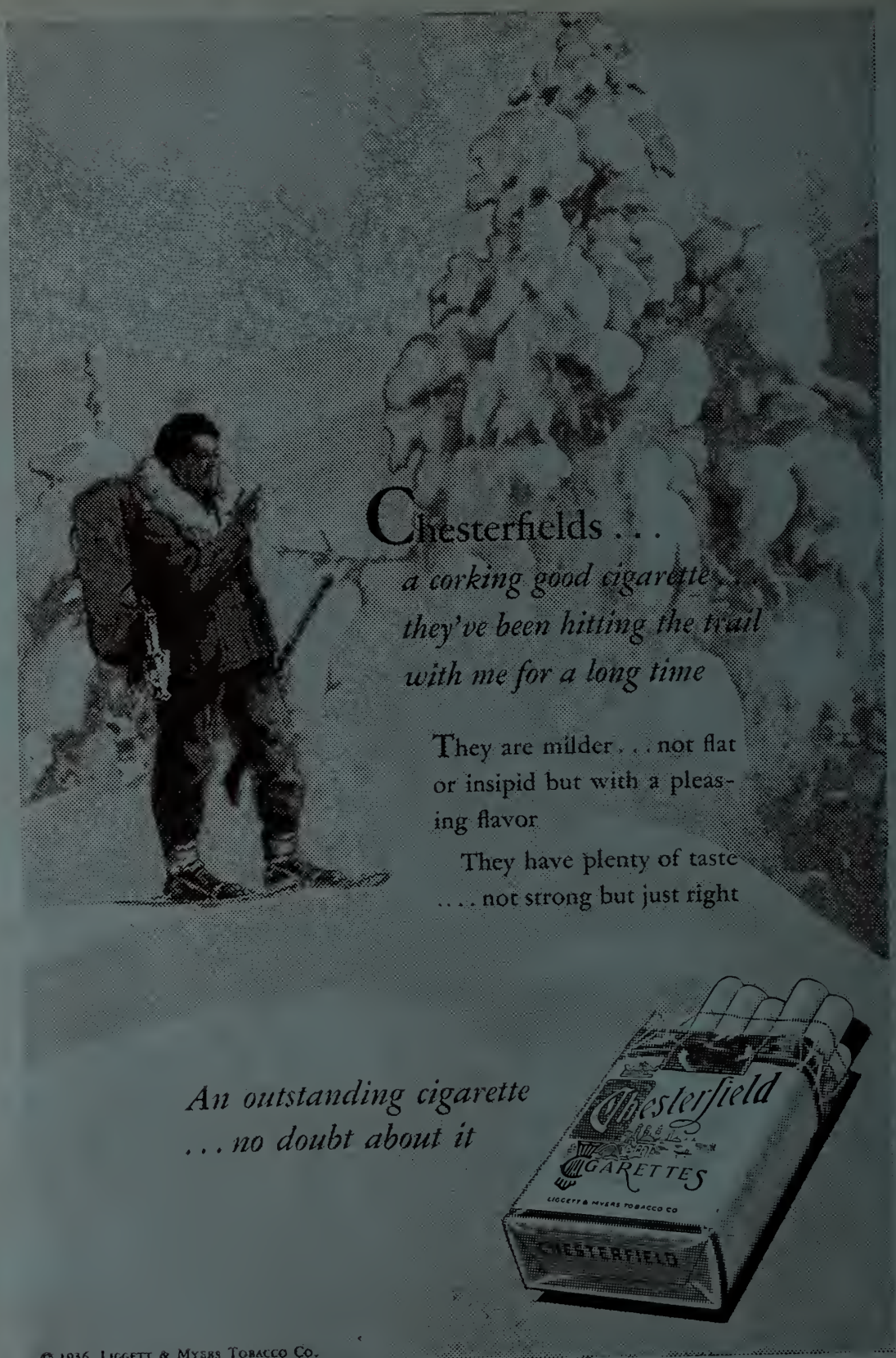
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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	J. E. Maines, Jr., M.D., 331½ W. University Ave., Gainesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Tuesday 12:00 noon	White House, Gainesville		
Bay	W. C. Roberts, M.D., Panama City	Allen H. Miller, M.D., Millville				
Brevard	I. K. Hicks, M.D., Melbourne	Bob Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies		
Broward	O. C. Brown, M.D., 915 Sweet Building, Fort Lauderdale	R. E. Blount, M.D., 360 S. E. 26th Ave., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale		
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	7	70%
Dade	John E. Hall, M.D., Box 2722, Miami	M. E. Threlkeld, M.D., Congress Bldg.. Miami	1st Friday 8:30 P.M.	Club Rooms Huntington Bldg., Miami	24	11%
DeSoto-Hardee-Highlands	C. H. Kirkpatrick, M.D., P.O. Box 454 Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies		
Duval	W. M. Shaw, M.D., St. James Bldg., Jacksonville	H. W. Porter, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville		
Escambia	A. M. Ames, M.D. Blount Bldg. Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola		
Hillsboro	G. C. Bottari, M.D., 1425½ E. Broadway Tampa	John S. Helms, Jr., M.D., P. O. Box 1439 Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa		
Jackson	C. C. Box, M.D., Graceville	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna		
Lake	J. D. Coupland, M.D., Eustis	W. L. Ashton, M.D., Umatilla	1st Thursday 12:30 PM.	Eustis		
Lee	William H. Grace, M.D., 15 Earnhardt Bldg., Fort Myers	H. Quillian Jones, M.D., 18-20 Leon Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers		
Leon-Gadsden-Liberty-Wakulla-Jefferson	R. F. Godard, M.D., Key Building, Quincy	B. A. Wilkinson, M.D., Telephone Bldg., Tallahassee	Quarterly 3:00 P.M.	Varies		
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison				
Manatee	H. Gates, M.D., P. O. Box 245 Bradenton	W. D. Sugg, M.D., Bradenton Bank Bldg., Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Club Bradenton		
Marion	J. L. Chalker, M.D., 719 E. Oklawaha Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala		
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies		
Orange	T. M. Rivers, M.D., Kissimmee	J. A. Pines, M.D., 106-10 E. Central Ave., Orlando	3rd Wednesday 8:30 P.M.	Varies		
Palm Beach	W. W. George, M.D., 1116 Harvey Bldg., West Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach		
Pasco-Hernando-Citrus	R. D.Sistrunk, M.D., Dade City	John J. Bourke, M.D., Dade City	2nd Thursday 7:00 P.M.	Varies		
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NOTE—Secretaries: Please submit information to complete the above schedule.



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Southern Medical Association, Baltimore, Md., November 17-20, 1936.

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CANNED FOODS AND THE PUBLIC HEALTH

I. The "Ptomaines"

• Many requests received for further information on canned foods have inquired as to some of the public health aspects of this class of foods. We appreciate the frank interest of our readers in this subject about which so much misinformation exists. We are glad, therefore, to devote this discussion, as well as subsequent ones, to the most popular of the lay misconceptions concerning the wholesomeness of commercially canned foods.

Some laymen hold the belief that canned foods, in some mysterious manner, develop "deadly ptomaines" within the can and hence the consumer of such foods stands in danger of "ptomaine poisoning". In the light of modern knowledge, this belief is ludicrous; it probably had its origin in the old "ptomaine theory" of food poisoning, now so thoroughly discredited by modern medical authorities (1).

Between the years 1870 and 1880, a large number of substances were obtained from protein material which had undergone bacterial putrefaction. These substances were aptly called "ptomaines", from the Greek "ptoma" or "dead body". Toxicologists of the day ascribed marked toxic properties to the new found ptomaines, chiefly by injection studies rather than by feeding tests.

The science of bacteriology was then in its infancy—the true causes of food infection or intoxications were not known. Consequently, the discovery of ptomaines, with their alleged toxic properties, permitted the convenient diagnosis of "ptomaine poisoning" for all illnesses following the ingestion of foods. Today, we know that such illnesses usually result from the ingestion of food which had been infected by certain bacterial groups, and not from protein degeneration products such as ptomaines (2, 3).

One authority has stated that "ptomaine poisoning is a good term to forget" (4).

To this we might add that it would also be well to discard the old, unfounded belief that foods in the tin can develop substances hazardous to health.

Canned foods are merely selected foods which, after proper preparation, are sealed in hermetic tin containers and given a heat process calculated to destroy pathogenic and spoilage organisms which might be present on the raw foodstuff. The hermetic seal prevents future infection of the food by such organisms and insures its preservation and wholesomeness.

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(1) Journal American Medical Ass'n. 90,459 and 1573 (1928).

(2) Food-Borne Infections and Intoxications, F. W. Tanner, Twin City Pub. Co., Champaign, Ill., 1933.

(3) Food Poisoning and Food-Borne Infections. E. O. Jordan, University of Chicago Press, 2nd Ed., 1930.

(4) Preventive Medicine and Hygiene, M. J. Rosenau. Appleton-Century, New York, 5th Ed. 1927, p. 668.

This is the ninth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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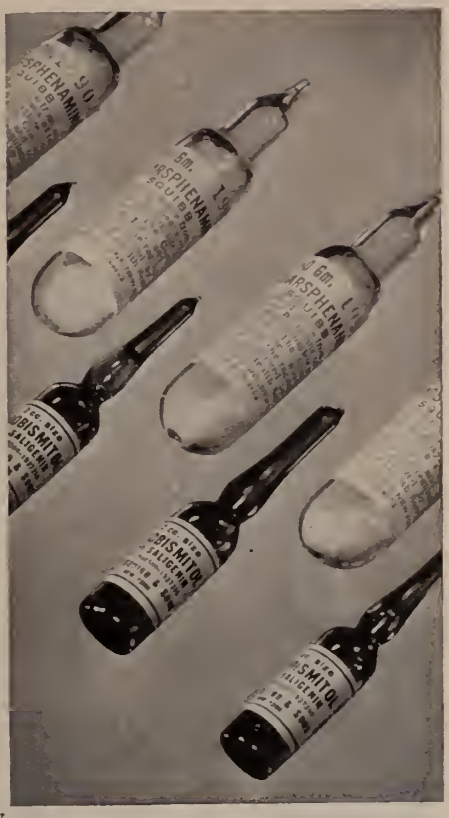


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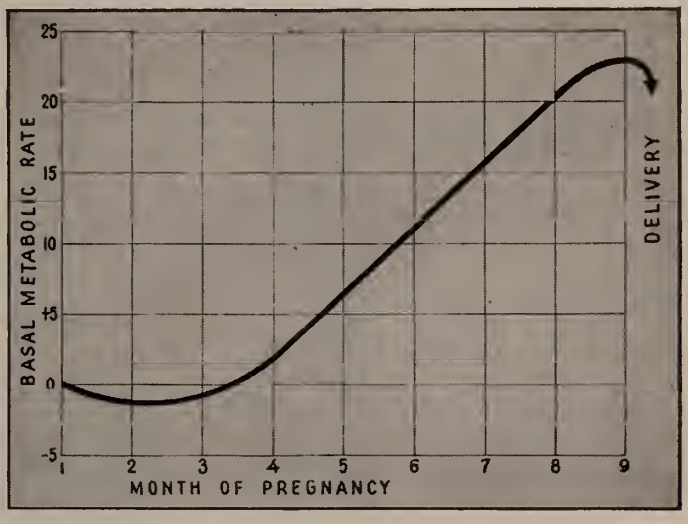
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OBSERVATIONS ON THE MECHANISM AND TREATMENT OF CIRCULATORY FAILURE*

E. W. Bitzer, M.D.,
Tampa.

There are many problems connected with circulatory failure, that have not been solved. There are three known factors, however: the mechanical, the metabolic and the vasomotor. It is necessary to emphasize that more than one of these factors usually is involved.

While it is true that mechanical considerations perhaps play a small part in circulatory failure, it is nevertheless necessary to have an adequate idea of this phase of the problem.

The circulatory system consists of two pumps and two sets of blood vessels: the left heart and the peripheral vascular system and the right heart and the pulmonary system. Any obstruction to the flow of blood at any point, if of sufficient magnitude, will result eventually in circulatory failure. This obstruction may be either cardiac or in the pulmonary vessels, or in the peripheral vessels.

Valvular heart diseases are a common example of obstructive phenomena in the heart. In aortic regurgitation and stenosis we see marked enlargement of the left ventricle to compensate for the defects. In mitral disease, pulmonary stenosis and tricuspid disease, and in most of the congenital heart diseases, the right heart is predominantly affected.

In addition to the valvular defects we have the conditions affecting the heart muscle itself, with the resultant decrease in the power of the pump. In the left ventricle coronary disease is the most common cause. Myocarditis, also, may be a cause for weakness of the muscle in the left ventricle. In the right heart beriberi,[1] myocarditis and coronary disease may be the etiological factors. Pericarditis, both adhesive and with effusion, interferes with the proper filling of the ventricles and consequently acts more or less as an obstruction in the circuit.

In the pulmonic system sclerosis of the pulmonary arteries is occasionally encountered. The possibility of obstruction, with enlargement of the right side of the heart from emphysema, is at the present time a mooted question.

In the peripheral vascular system hypertension is the common obstructive factor, due to a spasmodic contraction of the small arteries and arterioles. The burden of this obstruction falls on the left ventricle.

In recent years more attention has been paid to metabolic considerations and to the study of normal and abnormal muscle physiology. It has been determined[2] that there are three things that are absolutely essential for the continued activity of the heart muscle: glucose, oxygen and insulin, in the absence of any one of which the heart will fail to beat. It has been determined also that the secretion of the thyroid gland plays an important part in the physiology of the heart.

Another cause of circulatory failure is the cardiac arrhythmias. The heart is built to function at a certain speed and whenever the rate is very much above or below this speed, it fails to function properly as a pump.

Heart block, with a slow pulse rate, is a common cause of circulatory failure. In Stokes-Adams' syndrome we have either a temporary or permanent cardiac standstill.

In the arrhythmias in which the pulse rate is above 140 we nearly always see evidence of circulatory failure, even in hearts that are not definitely pathological.

In auricular and ventricular paroxysmal tachycardia the pulse rate is under 200, usually from 160 to 180. If the paroxysm is prolonged, at times we see definite signs of circulatory failure. The arrhythmias that cause a heart rate of over 200 per minute are auricular fibrillation, auricular flutter and ventricular fibrillation. In paroxysmal fibrillation and in the beginning of chronic auricular fibrillation we always have a rapid pulse, but not necessarily over 200 per minute. In auricular flutter the rate is usually a rapid one but frequently a partial block reduces the

*Read before the Sixty-Second Annual Meeting of the Florida Medical Association, Ocala, May 13-15, 1935.

rate to under 200 per minute. In auricular fibrillation, unless a high grade block is developed, naturally we often find evidence of circulatory failure. In auricular flutter, circulatory failure is not so common, though it does occur at times. Ventricular fibrillation may be a terminal event in various types of cardiac cases. This means, of course, that the ventricles cease to function and death follows immediately.

CLINICAL TYPES OF CIRCULATORY FAILURE

There are at least three clinical types of circulatory failure: the anginal type, congestive failure or the plus type,[3] and vasomotor failure, or the minus type.

Anginal failure: The current explanation of angina pectoris is coronary disease plus a spasmodic contraction in the coronary arteries. Recently it has been suggested that in certain cases failure of the dilator mechanism may be the most important cause.[4] For many years it has been maintained that the nervous system played an important part in angina pectoris,[5] and it seems quite likely that this is the case, though it never has been definitely proved.

Congestive failure: This is the type of circulatory failure most commonly encountered and occurs in many types of heart disease. It is associated with more or less generalized edema, enlargement and tenderness of the liver, pulmonary edema and shortness of breath, both after exercise and when lying down. It has been shown that this type of failure is characterized by an increase in the volume of the circulating blood and a definite increase in the venous pressure.

Vasomotor failure, the minus type: This is the type of circulatory failure seen in shock and acute infections, diabetic coma, acute diarrhea. There is an actual decrease in the volume of circulating blood, also a decrease in the venous pressure. Shortness of breath is absent when at rest but may be present on exertion. Edema is absent.

In addition to these types some consideration must be given to the clinical aspects of failure of the left and of the right side of the heart. Wenckebach[6] states that eventually in all types of cardiac failure there is a failure of both the left and right ventricle. At times, however, we see more or less true failure of one ventricle alone, usually the left, but occasionally the right.

In failure of the left ventricle the essential characteristics are orthopnea, Cheyne-Stokes' respiration, edema of the lungs and the absence of swelling of the liver or extremities.

In failure of the right ventricle alone, edema of the lungs is absent. Swelling of the liver and the extremities is a characteristic sign. The only condition in which failure of the right ventricle is common is beriberi.

It may be stated here that more than one type of failure may be present in a case and the same case may rapidly pass from one type of failure to another. As an illustration of this we see in the early stages of coronary thrombosis the minus type, with a decreased blood volume and low venous pressure associated with a drop in the blood pressure. Frequently this is followed in a short time by the plus type, with an increase in the circulating blood volume and an increase in the venous pressure. This is not universally true. It has been shown that patients who have had previous heart failure[7] frequently are the plus type, even in the early stages. A recognition of this condition is essential in the treatment.

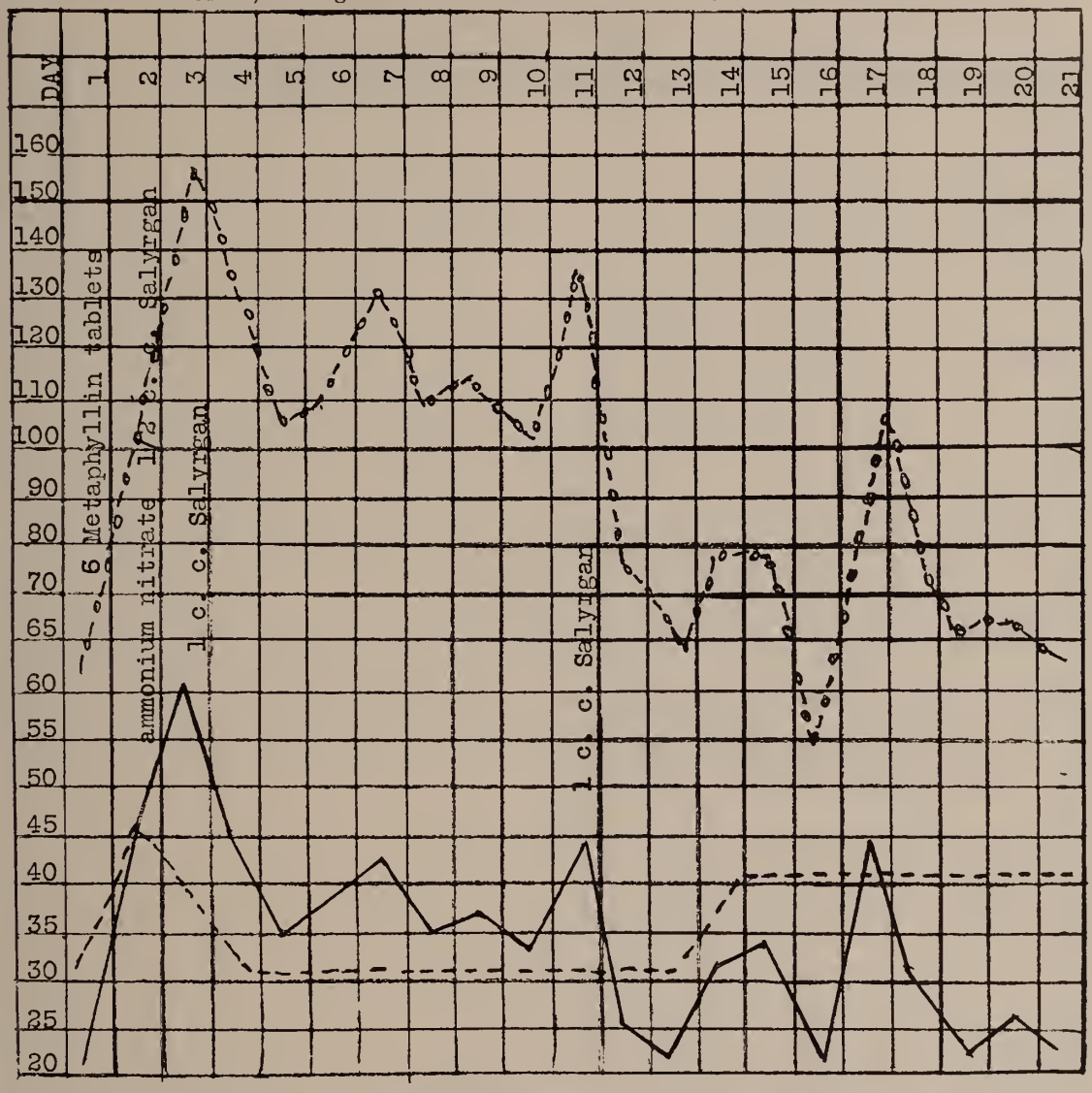
TREATMENT

Angina pectoris: The nitrites have been used for years in the treatment of angina pectoris and usually relieve the pain. Theobromine is even more effective in most cases. Both of these drugs are supposed to increase the coronary circulation; also to dilate the peripheral vessels. Theophyllin has somewhat the same effect but is more powerful than theobromine as a diuretic and inasmuch as it frequently occurs that there is a mild congestive failure with the anginal failure, diuretics are useful. Smith[8] has found that the use of glucose and small doses of insulin are of great value and he claims that some cases are actually cured by this treatment. Levine[9] has shown that removal of the thyroid gland will relieve the pain in angina pectoris. It has been known for years that thyroid, administered by mouth, is likely to increase the pain.

Congestive failure, plus type: The first indication for treatment in this type is to decrease the blood volume. For this reason digitalis and strophanthin are both indicated. A salt-free diet also has a tendency to make the tissues give up their fluids. Diuretics are very serviceable. Soluble theocin and metaphyllin, by mouth, are the most useful. Salyrgen, intravenously, either alone or combined with the oral administration of ammonium nitrate, is effective and usually leads to a rapid dehydration, with a loss of the

FIG. I.

A case of rheumatic heart disease in a state of decompensation, with a congestive failure and generalized edema, showing the method of treatment and the response to diuretics.



---- Fluid intake in ounces. ——— Urinary Output in ounces. o-o-o-o Percentage of fluid intake passed as urine.

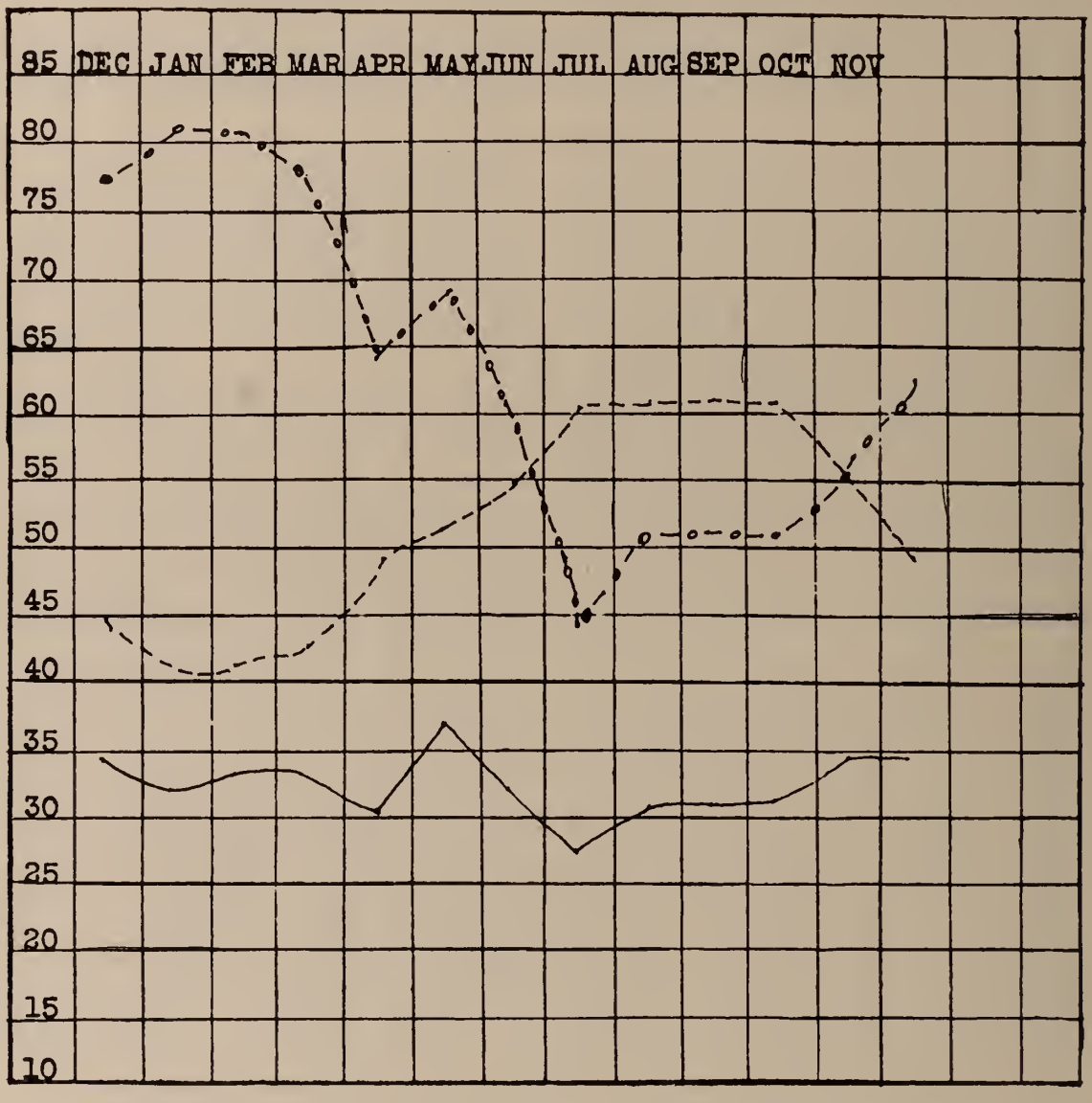
swelling in the extremities, in the liver and in the lungs.

An adequate study of the water metabolism is essential in the treatment of these cases; a daily chart of the intake of fluids and output of urine should be kept. In cases with frank congestive failure it is advisable to restrict the fluid intake to one quart in twenty-four hours. Figure I illustrates the value of diuretics. For the first ten days the excretion of urine exceeded the fluid intake and the percentage of the fluid intake excreted as urine reached a high point of 156%. On the twelfth day dehydration was completed and it became necessary to increase the fluid intake to 42 ounces daily.

Figure II is a year's record of the water metabolism of a hypertensive heart case that had had a congestive failure when first seen. The fluid intake was reduced to the lowest point compatible with the excretion of one quart of urine daily. During this year there was no evidence of congestive failure. The urinary output was fairly level between 30 and 35 ounces daily, but the fluid intake fluctuated from 42 ounces to 62 ounces. The percentage reached the high point in January, 82%, and the low point in July, 45%. This is a simple method of treatment that avoids the unnecessary strain on the cardiovascular system of gross fluctuations in the fluid intake.

FIG. II.

The water metabolism in a chronic cardiac patient showing the seasonal variation in the percentage of urinary output and illustrating the method used to keep the urinary output around 32 ounces in 24 hours.



---- Fluid intake in ounces. ——— Urinary Output in ounces. o-o-o-o Percentage of fluid intake passed as urine.

In emergencies, elevation of the head and shoulders has a tendency to relieve somewhat the burden on the right heart. A tourniquet on the extremities, cutting off a portion of the circulating blood, may also be used. Bleeding serves the same purpose. Glucose solution, from 25% to 50%, intravenously, is at times a very useful dehydrating agent. The use of glucose by mouth, with small doses of insulin is a valuable adjunct in the treatment of severe cases. It is also necessary to prescribe a simple diet, with a high carbohydrate content. In severe cases of failure, inhalation of oxygen often gives considerable relief. It has been shown[9] that removal of the thyroid gland will relieve congestive failure.

Vasomotor failure, minus type: The indication for treatment in this condition is to increase the circulating blood volume. This may be done by transfusion, normal salt solution, intravenously, or by forcing fluids by mouth. Vasomotor stimulants are indicated, such as strychnine, adrenalin, pitressin, camphor and caffeine. Digitalis is contraindicated, for the reason that it decreases the circulating blood volume. Elevation of the foot of the bed is helpful. Bandaging the lower extremities, from the feet to the hips, and abdominal pressure, in order to get

more blood into the heart and the coronary arteries, is often effective in emergencies.

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DISCUSSION

Dr. E. W. Bitzer, Tampa (concluding):

This paper has covered a large field and my excuse for presenting it is the fact that sometimes it helps to assemble our knowledge of a subject and look at it as a whole.

The one thing, however, that I wish to emphasize particularly is the study of the water metabolism in cases with congestive failure. I have a feeling that this is a very much neglected part of the treatment of cardiac failure. In many hospitals it is customary to restrict the fluid intake. It is necessary, however, to stipulate definitely how much should be taken and a record should be kept continuously of the output of urine.

Of course, I realize the fact that keeping the record of the fluid intake is not at all an accurate thing, but it gives a general idea of the water metabolism in the patient. It is important to keep the fluid intake at the lowest point compatible with the excretion of a quart of urine a day.

THE FLORIDA MEDICAL ASSOCIATION AND PUBLIC HEALTH*

HERBERT L. BRYANS, M.D.,
Pensacola.

I bring you greetings from the Florida Medical Association and esteem it a privilege to address you on this occasion. It is the natural desire of one selected to speak on such a subject to say something that will be helpful in the future of those most concerned, namely, those practicing medicine and those doing strictly public health work. This is not easy, but it occurred to me that a frank discussion at this time may serve a useful purpose in the continued cordial relationship of public health agencies and the medical profession.

It is almost impossible for us today to visualize the extreme distress, fear, and suffering that existed during the dark periods of ignorance, dirt, disease, pestilence and death. To appreciate the great advancement that medicine and sanitary science has made since those dark ages, it is only necessary to note the relative security from disease that characterizes this century. The application of modern science to the prevention of disease has produced results so spectacular that they could hardly have been visualized half a century ago.

The early history of the Florida State Board of Health is intimately associated with the sponsorship of Dr. John P. Wall, of Tampa, a past-president of the Florida Medical Association who at the close of his address before the Association at Sanford in 1885 said: "Before closing I would briefly call your attention to some needed legislation, as much, if not more, in the interest of the people as that of our profession. In the first place, the need of a State Board of Health is manifest; heretofore we have met with failure in several efforts to get the Legislature to enact the necessary laws to establish one. One cause of failure is doubtless owing to lack of information on the part of the people as to its necessity and the work to be accomplished. But even if established, such a board is not likely to prove a success unless cordially supported by the profession of the State."

Again on May 19, 1886, during the regular session of the Florida Medical Association held in Palatka, the President, Dr. N. D. Phillips, of Gainesville, requested Dr. R. B. Burroughs, chair-

*Read before the Seventh Annual Meeting of the Florida Public Health Association, Orlando, Dec. 2, 3, 4, 1935.

man of the Special Committee on State Board of Health, to make his report and recommendations. In his brief report the Legislature was to be requested to establish a State Board of Health and County Boards of Health who would have supervision of all matters relating to public health, with such duties, powers and responsibilities as may be prescribed by law. This report was received and the Committee continued.

The Florida Medical Association continued its efforts in behalf of this Bill until the State Health Department was created in 1889 under Dr. Joseph Y. Porter as its first Commissioner of Health.

Since its establishment the Florida State Board of Health has experienced a remarkable expansion and development in spite of a woeful lack of funds, at times interference by party politics and the scarcity of personnel well trained in the science of public health.

The practicing physician is, by tradition, interested in public health problems, in fact his active interest is more manifest today than ever before. Occasionally we hear physicians complaining of encroachments on their private practice by public health departments or private health organizations, but it would appear that when such a complaint or situation does arise, it can usually be traced either to a misunderstanding on the part of the physician or to a misdirected zeal on the part of the health worker. However, the depression has produced innumerable forces that seek to change the existing order of things and organized medicine is looking with apprehension at these social security measures as the opening wedge for a social reorganization through regimentation of our profession.

Organized medicine and public health agencies are so closely interwoven that one is mutually dependent upon the other. Each is a highly specialized branch of medicine and must continue on a cooperative basis, remembering the old established principle that the practicing physician is an essential element in public health practice.

Those individual grievances that occasionally arise between public health agencies and practicing physicians are at times also occasioned by the local health departments not advising with the local medical profession in originating and carrying through public health measures.

The control of disease depends largely upon the intelligent appreciation of its etiology by the laity and upon the cooperation of the medical profession, but sporadic and unorganized efforts will never solve our local problems.

I have read somewhere that, out in the solitude of a great desert, when a caravan is in danger of perishing for want of water, they give one camel its head and turn it loose. The inherent instinct of the animal will lead him unerringly to the refreshing spring. As soon as he is but a speck on the horizon, one of the Arabs mounts and sets off in the direction taken by the liberated animal. When he in his turn is just visible, another Arab mounts and follows. When the loose camel discovers water, the first Arab signals to the second, the second to the third and so on until the message is relayed back and all the members of the party are gathered at the life-giving spring.

This is teamwork and there are many ways in which organized medicine and public health agencies, as individuals, can utilize this principle in carrying on the education of the public to care for itself by immunity procedures, to feed the baby and other members of the family; to dispose of wastes in a sanitary way, to light and heat and ventilate the home and factory; to preserve the teeth, eyes and ears; to recognize disease that requires consultation with the family doctor; and to observe the many other laws of health.

The public is fast learning that it is cheaper to stay well than to permit sickness to develop and then travel the road to Wellville. The activities of State and local Boards of Health and the U. S. Public Health Service are responsible for the greater part of this education.

The Florida Medical Association called a general conference with representatives from the State Dental Society, State Pharmaceutical Association, State Board of Health and the State Board of Social Welfare. At this meeting the Florida Advisory Council for Medical Relief was organized to consist of one representative from each of the above groups.

This Council made formal request on September 26, 1935, to the Honorable Harry L. Hopkins, Administrator, F. E. R. A. and W. P. A., for a grant of funds to this State to provide medical and dental services, drugs and prosthetic devices to persons who by reason of no income or inadequate income might be unable to provide such services for themselves. This request for Federal funds was denied. It was brought out by the Council that the doctors, dentists and druggists, out of their own time and resources,

had heretofore largely supplied these needs, except during that period when F. E. R. A. shared part of these activities.

Services of this kind should not be the entire responsibility of the medical and allied professions, but a joint obligation between the professions and society. Provisions were made for the medical needs of those individuals whose incomes are sufficient to remove them from the indigent class, yet insufficient to permit the payment of prevailing medical fees, by an adjustment of these fees commensurate to their income.

It is the desire of organized medicine in this State to cooperate with City, County, State and Federal Agencies in dealing with health problems, but it must be understood that professional services cannot be dispensed like merchandise.

Public Health Agencies can accomplish what the individual physician cannot in tracing epidemics to their sources and instituting proper measures to prevent their spread and recurrence. For generations physicians have always been earnest and helpful in the application of preventive measures but these measures can no longer be carried out by practicing physicians alone.

The modern public health officer is truly a highly trained specialist in preventive medicine. He has the supervision of water, food and milk production with laboratory control, venereal disease control, anti-tuberculosis measures and propaganda, inspection of food handling establishments, inspection of school children, control of flies, mosquitoes, rats and other vermin, the management of diagnostic laboratories, the campaign against cancer, the war against fake practitioners and the regulation of habit-forming drugs, quarantine regulations, disinfection of homes, control of housing regulations, control of epidemics, the appointment and activities of public health nurses, the maintenance of the important branch of Vital Statistics without which the public health activities would be without the means of taking inventory. His constant aim is to preserve a wholesome relationship between physicians and their clientele by educating the people to seek their family doctor for advice on all matters pertaining to health, prevention and the cure of disease.

If writers who are so little informed on the expense of medical care and are so interested in trying to assist economically the people would give their time and effort in endeavoring to educate the public to disregard non-essentials and prepare for those emergencies which come to all of us, they would be rendering that public a greater service than by discounting the doctor or health officer through efforts to prejudice the public against just charges for professional services which spare neither time nor money to prolong life and improve the health of the community. Whenever the people themselves are sufficiently informed and interested there will be no further need to worry about legislation or the enforcement of health regulations.

AFTER CHOLECYSTECTOMY*

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DeLand.

It is not without hesitation that a paper on the subject of the sequelae of cholecystectomy is attempted, for there is much uncertainty and confusion. It is a subject in which our knowledge of function is not complete and in which forms of therapy are still being evolved. Accurate statistics are lacking concerning symptoms after cholecystectomy and the evaluation of symptoms other than pain after operation is difficult. Where poor appetite, constipation and indigestion three years after a cholecystectomy may be a diagnostic problem to the internist to evaluate their relationship to the previous surgery, too often such symptoms are passed over as unrelated to the biliary tract or due to neurotic tendencies. The fact is, however, that not all cases of chronic cholecystitis, with or without stone, are cured by cholecystectomy, and some (though less) are not helped at all. Deaver[4] once said: "It may be true that gall-bladder patients are none the better for having been operated on, but most often it is not the whole nor nothing but the truth . . . and the fact remains that the majority of patients are relieved by operations on the biliary tract." But what of the minority (variously estimated as from 2-20%) that are only partially or not at all relieved? The internist is too prone to cry out that the surgeon has done no good, without considering how much of the postoperative symptomatology may be due to lack of control, and the surgeon is often too ready to protect himself with the statement that only he knows exactly the degree and extent of the pathology present and therefore how much worse off the patient would have been without the operation, and too often the removal of a grossly normal

*Read before the Volusia County Medical Society. New Smyrna, February 12, 1935.

gall-bladder has been justified by a microscopic diagnosis of infection. None of these attitudes is likely to be of much benefit to a patient suffering with symptoms after a cholecystectomy. It is evident from reports of Muller,[17] Judd and Priestley[11] that cholecystectomy is followed by fewer recurrences than cholecystostomy, but no one has ever found 100% of cures from cholecystectomy. Ivy[10] has stated that "physiologic and anatomic changes do result following the removal of the gall-bladder, so that its removal as a vestigial organ is not justified."

After cholecystectomy there is usually a readjustment process. A compensatory dilatation of the common duct takes place. This occurs within a few months of operation and takes care of the balancing of bile pressure formerly regulated by the gall-bladder. Ivy states that "the sphincter of Oddi becomes incompetent soon after removal of the gall-bladder showing that the gall-bladder has some functional relation to the sphincter. Later in most instances the sphincter becomes sufficiently competent to cause the ducts to dilate." In some patients there is pain associated with this readjustment, usually attributed to spasm of the sphincter. For this reason Deaver[5] advocated the dilatation of the sphincter at operation, but it is conceivable that such an incompetent sphincter will favor regurgitation and reinfection. There may be insufficient dilatation of the common duct because of adhesions around it or infection in its walls, and this may cause postoperative pain. Treplen[25] observed that this readjustment pain was more likely to occur in patients who had a cholecystectomy before entire loss of function of the gall-bladder so that there was little or no dilatation of the common duct to begin with. However, pain after a cholecystectomy is not likely to persist if it is due to this physiological readjustment, but because this readjustment is interfered with by such processes as infection in the wall of the duct, adhesions around it, or strictures of the common duct.

It is not exceedingly rare that in cases of long-standing biliary tract disease stones are formed in the hepatic or biliary ducts and escape observation at operation. That these may cause recurrence of symptoms has been proven by observations at secondary operation, and it has been known that stones form in the common duct after cholecystectomy, though Judd[12] believes it to be quite rare. Associated with these stones the surgeon often sees evidences of diffuse hepatitis and cholangeitis, which are resistant to all forms of treatment. T-tube drainage may produce results in some of these cases, but to suppose that it will cure any cholangeitis is to assume too much regarding the regenerative ability of the liver cells. In 1921 Judd[12] stated that cholecystitis rarely exists without hepatitis, and that no amount of surgery would cure hepatitis if of too long a duration. In evaluating symptoms after a cholecystectomy we must, then, consider the postoperative physiology of the biliary tract, unavoidable errors in surgical technique and the amount of damage to the liver parenchyma.

Another important consideration in this problem is the question of diagnosis. If the preoperative diagnosis has been hasty and ill founded and a normal gall-bladder removed at operation, it is to be expected that symptoms will recur. Graham[6] and Ivy[10] have emphasized this. Muller[16] in 1925 suggested that faulty diagnosis may be related to postoperative failures by the analysis of cures following operations on the calculous and non-calculous types. Eighty-four and four-tenths per cent of the calculous were cured against 70% of the non-calculous. Whipple[31] found 89.4% of the calculous type cured by operation as against 76.6% of the non-calculous. Olch found almost 100% cured in which the diagnosis had been based on abnormal cholecystograms. Graham[6] found only 60% well after operations in which no stones were found, and added, "if the patient happens to have another unrelated lesion that is responsible for many of the symptoms, it is obvious that removal of the gall-bladder will not give satisfactory relief, despite well marked disease in the latter organ," and Deaver insisted that many of the postoperative symptoms were due to reflex disturbances in the stomach which had existed before; one of these, pyloric stenosis, he attempted to relieve by partial pylorectomy at the time of cholecystectomy. However, even if diagnoses were 100% correct, if hidden stones were always found, and if stricture of the common duct was preventable, there will be patients who will complain after cholecystectomy. These will be due to diffuse hepatitis or disturbances of the function of the biliary tract. This function of the biliary tract after operation is little understood. That many patients never need any medical treatment after cholecystectomy is admitted, but there are a few who because of the persistence and intractability of their symptoms need much help and are difficult to handle.

In any plan of control of patients with postoperative symptoms, we must consider the normal physiology of the gall-bladder and what effects such loss of function will entail, and we must study any compensatory mechanisms set up. If our knowledge of the normal physiology of the biliary system is at present incomplete, its physiology after cholecystectomy is even less understood.

One of the functions of the gall-bladder is to serve as a reservoir of bile. This bile is important because of its excretion of bile salts and pigments, its role in digestion, and in the metabolism of cholesterol. That this reservoir exists and empties periodically has been demonstrated by Ivy[9] and he has shown that this depends on hormones developed when certain foods reach the duodenum. Halpert[8] maintains that the function of the gall-bladder is one of reabsorption and not storage or concentration, and though his theory would be of help in explaining postoperative symptoms, it would not explain that majority who have lost this reabsorptive membrane without any ill effects. After this reservoir is gone does the bile flow continuously into the duodenum or is there some compensatory mechanism set up? That the ducts dilate, we have mentioned before. The ducts often dilate considerably. In the mucosa of the common duct and larger bile ducts Sweet has demonstrated small outpouchings which after cholecystectomy dilate and store bile; as he has shown in animals after cholecystectomy and in those who have no gall-bladder. Mechanical interference of this dilatation will produce symptoms. Infection in the wall of the ducts may interfere with proper storage of bile by causing loss of normal elasticity. These will produce stasis, which favors infection of the bile. These conditions will require secondary surgery to remove adhesions, strictures or stones, or prolonged T-tube drainage for infection. As Moynihan[14] preached, cholecystitis or symptoms referable to the common duct are due to infection; stone is secondary. So after cholecystectomy, symptoms are more likely to be due to infection than to stone. It is evident that after cholecystectomy there is storage of bile, which when interfered with, will produce symptoms.

A second function of the gall-bladder is concentration of bile. Rous and McMaster[24] have shown that this concentration is rapid in the gall-bladder. It is supposed that concentration favors emulsification of fats in the intestinal tract. There is no convincing work at hand to demonstrate that bile is or is not concentrated in the dilated ducts after cholecystectomy. It is suggestive that on biliary drainage by duodenal tube one can get dark, viscid bile similar to the so-called b-bile of the gall-bladder. On two patients (three and five years respectively after cholecystectomy), I have on four occasions tried tube drainage according to the method of Twiss[26]. In each of the eight trials little bile was obtained until magnesium sulphate or olive oil was introduced into the duodenum, when almost immediately 30-40 cc. of dark, olive-green to brown bile was obtained, to be followed by larger amounts of thin, clear yellow bile. Westphal[29] describes similar results, though he obtained greater amounts of concentrated bile. That this response of the sphincter and common duct exists is explainable on the same basis of the Doyon-Meltzer concept of reciprocal innervation between the sphincter and the gall-bladder, for the musculature of the gall-bladder and common duct are the same in kind if not in degree, and both are supplied by the same motor parasympathetics and inhibitory sympathetics. So concentration of bile in the common duct after cholecystectomy seems likely, and with this concentration come the same problems of increased concentration of bile pigments, cholesterol, bile salts and the possibility of infection from stasis. It speaks well for our techniques of cholecystectomy and t-tube drainage that such a small percentage of patients have difficulty with these readjustment problems and reinfection.

In considering the fate of the bile constituents we know that the bile salts and pigments are excreted and later reabsorbed in the intestine, regardless of whether they were in concentrated or diluted bile. In cases of stasis, precipitation may occur, especially if infection is present, but the absence of the gall-bladder has no influence per se on the excretion of bile salts or bile pigments. The role of cholesterol in symptoms after cholecystectomy is on no firmer or surer basis than is its role in gall-bladder pathology. Cholesterol is found regularly in the blood and bile and is more than an ordinary waste product for it is one of the constituents that gives bile its peculiar ability to emulsify and facilitate the digestion and absorption of fat in the intestine. It can be increased in the bile by excessive ingestion,[19] though its concentration in the blood is fairly well regulated at a constant level except for the

normal diurnal variations.[2] After certain types of meals blood cholesterol rises with a later marked increase in bile cholesterol.[18] Early investigators regularly reported hypercholesterolemia in association with gall-stones, but it is now proven that cholesterol levels in the blood are unrelated to cholelithiasis. The excretion of cholesterol into bile is independent of its concentration in the blood,[20] and it is obvious that the composition of bile when stones are formed depends not only on the quantities of the components excreted by the liver, but also on the extent of subsequent concentration by the gall-bladder.[21] If there is a relationship between stone and cholesterol, it must be explained on the concentration in the gall-bladder or common duct. If high concentration of cholesterol in the common duct after cholecystectomy favors stone (we aren't sure), we must be careful after cholecystectomy to prevent its high concentration in bile. This is attempted by (a) keeping down the intake of excessive amounts of cholesterol, (b) preventing infection or securing adequate drainage of infection, (c) preventing biliary stasis, and (d) preventing too rapid losses in weight as it has been shown that starvation increases cholesterol excretion.[3, 19] High concentrations of cholesterol also occur in pregnancy[28] and in obesity there are disturbances in cholesterol metabolism.[13] The role of cholesterol and the other constituents of bile is, then, no more understood after cholecystectomy than before it and the possibility of postoperative symptoms resulting from disturbances in the metabolism of these constituents, no matter how inviting in theory, remains to be proved or disproved. Until we know more of the true roles of cholesterol, it might be wise to keep down its concentration in bile as far as possible.

Studies of bile concentration according to the Gregory-Pascoe[7] methods of bile analysis have been carried on recently by many experimenters, especially Ravdin.[22, 23, 1] With increasing loss of function of the gall-bladder, the concentration of calcium and bile salts progressively decreases, while chlorides progressively increase. Cholesterol will vary widely, though roughly it follows the concentration of the bile salts. There are exceptions, but in the main results of different investigators agree. Such studies are valuable and should be applied to patients complaining of symptoms after cholecystectomy as a possible aid in diagnosing the functional ability of the dilated common duct. Such studies have not been reported.

What then can be done for these sufferers after cholecystectomy? A correct diagnosis is essential. We must decide if the symptoms are due to disturbed biliary function, incomplete surgery, recurring infection, stricture of the common duct, adhesions or spasm of the sphincter of Oddi. We must consider other lesions which may be causative. Chronic appendicitis with pyelephlebitis may cause symptoms referable to the biliary tract. The production of pancreatitis and duodenal ulcer from chronic biliary tract infection was a favorite topic of discussion by Deaver.[4] He also pointed out that low grade catarrhal gastritis with low acidity or anacidity sometimes follows biliary tract disease and will persist after cholecystectomy. The possibility of pyloric stenosis has been mentioned. Graham has stated that some of common conditions which may give symptoms wrongly diagnosed as of biliary origin are: osteoarthritis of the spine, chronic constipation, diseases of the right kidney and urinary tract, and duodenal ulcer.[6] These conditions must be considered in the evaluation of complaints after cholecystectomy, and we must know not only that the patient's gall-bladder was removed, but also the condition of the liver and pancreas at operation.

Obviously if stones persist in the hepatic ducts or are reformed and their existence can be proven, or inferred, or if infection is present, further surgery is necessary and holds the only hope for any benefit. But too often stone or infection cannot be proven, and we are forced to conclude that disturbed physiology is the basis of the symptoms, neurosis or extrahepatic and extrabiliary conditions having been ruled out. The treatment of these is difficult.

By attention to hygiene, especially oral and intestinal hygiene, much can be done to eliminate the possibility of recurrent infection. Regular habits, moderate exercise, deep breathing, avoidance of constipation, freedom from mental strain and worry are all details which the physician must supervise for they are of more than academic interest and usually little understood by the patient. Removal of foci of infection is as important as it was before cholecystectomy. The prevention of biliary stasis is very important; it can be accomplished by stimulating bile flow by means of bile salts and duodenal tube drainage. The value of methenamine and other so-called bile

antiseptics is questionable. The treatment of reflex gastric disturbances is medical; alkalis, antispasmodics or dilute hydrochloric acid as indicated. Sedatives such as barbital and sodium bromide are valuable in the nervous and irritable patient. Careful adjustment of the activities and energy of the nervous patient is required. In no case is there any short road to relief. Each patient must be treated individually and each symptom evaluated.

The most important part of the treatment in these cases of disturbed physiology is the diet. In arranging such diets a number of factors must be considered. The liver, because of some injury associated with infection, is unable to completely metabolize protein cleavage products, and protein restriction in the diet must be commensurate with the amount of liver damage. Carbohydrate because of its protective action on the liver is indicated, and Wohlrabe[32] has shown that animals with injured livers live longer on a low protein and high carbohydrate diet. Fats, because of their demands on the biliary system, are to be avoided. Any diet for these patients must be of the bland type. Frequent feedings will prevent many gastric symptoms. Prevention of rigid dieting and food fads is to be insisted upon. The diet must be carefully planned for each individual to suit his activity, his nutrition and his symptoms. Wilensky[30] has discussed the relationship between postoperative symptoms and diet, emphasizing a low intake of fat and lipoid producing foods. Twiss and his associates[27] have developed special diets which will be found of value in this field. They describe the low cholesterol, low fat and low calory; the low cholesterol, low fat and high calory; the bland low cholesterol for gastric hyperacidity; the high cholesterol, low caloric; and the high cholesterol, high caloric diets. The two latter types which contain much cholesterol are used in patients where stimulation of bile flow is desired because of atony. Otherwise it would be well to use diets containing low cholesterol value. If consideration is given to the physiologic disturbances responsible for the symptoms in these patients, and if treatment is based on physiologic principles, especially in the dietary management, improvement is possible by medical management for those patients who have symptoms after cholecystectomy in which stone and reinfection have been ruled out.

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FUNGOUS INFECTIONS OF THE HANDS AND FEET*

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Recent medical literature reveals no other problem in cutaneous medicine which has attracted so much general attention, absorbed so many workers in its study and still offers more problems to be solved, than that of the fungous diseases. Although a majority of the infections occur on the skin the condition may be systemic and involve the lungs, central nervous system or almost any tissue of the body. Moreover, those organisms which confine their attack to the skin and its appendages have been shown by immunologic and allergic investigations to bring about certain changes in the host which may lead to a variety of eruptions in which the causal organism cannot be demonstrated. It can no longer then be considered as a purely local parasitic disease.

Before turning to the new problems which have been disclosed there is one clinical observation which is of interest to all. This concerns the apparent increase of dermatomycosis of the hands and feet, the variety ordinarily referred to as "athlete's foot." The figures given vary from 60% and even higher in certain selected male groups where the diagnosis is made solely on clinical inspection[1] to an approximate 10% for all types of mycotic eruptions in one of our largest city clinics. A brief consideration of the following table taken from the figures given by Sohrweide in a recent article[2] will illustrate the past incidence and the recent increase in the use of this diagnosis. The figures given represent all types of dermal mycotic infections and not merely those common to the extremities.

The Incidence of Tineal Infections

Observer	Period Covered	Number of Cases	Order of Incidence	Percentage Incidence
Crocker	1903	10,000	....	3.18
Bulkley	1898	10,000	8th	.96
Pollitzer	1878-1911	679,376	8th	3.2
Pollitzer	1916	58,387	9th	2.8
S. & C. Hosp.	1913-1917	44,386	8th	3.
S. & C. Hosp.	1918-1920 & 1922	62,698	9th	2.
S. & C. Hosp.	1923-1927	108,283	9th	2.
St. Sq. Hosp.	1928-1933	138,960	4th	10.2

Part of this material was reported by Goodman[3] six years ago and the most striking feature since that time has been the jump of the fungous infections from their traditional position of eighth or ninth place to fourth. This trend is frequently discussed and it reflects I think both an apparent increase due to a broadening of our concept of fungous disease and an actual increase due to conditions of modern living which favor their spread.

Another question of importance and one which is frequently asked by visitors concerns the relative frequency of such infections in Florida and in other parts of the country where a colder climate prevails. My impression is that the condition is not more common, all groups considered, but my records for a period of one and a half years show that a diagnosis of some type of mycotic infection ranks first in frequency and represents 9% of all diagnoses made. Of my patients 14.7% had one or more types of dermatomycosis and of this group 71% presented involvement of the feet.

In spite of the common occurrence on the feet I find that definite mycotic eruptions on the hands are fairly infrequent. Where I have 102 patients with ringworm on the feet, with 48% microscopically positive, I list only two with eruptions on the hands which could be proven to be mycotic by demonstration of the mycelium. In both instances it was associated with a fungous infection of a finger nail. Becker[4] states that dermatomycosis of the hands is rare and that in seven years in his clinic at the University of Chicago only six cases have been observed. Goodman made a similar observation on the patients at the Skin and Cancer Hospital in New York City.[5]

The infrequent finding of the mycelia in infections on the hands particularly in the acute vesicular eruptions led to the conception of the lesions as being toxic or secondary or allergic manifestations which were due to a focus of tineal infection usually on the feet. This conception is backed by considerable immunologic and allergic evidence on an experimental basis as well as by careful observation and should be held in view as an important factor both in diagnosis and treatment. Feet should never escape careful examination in a patient presenting an eczematoid or a vesicular eruption on the hands. These secondary eruptions which are rather common on the hands are termed "trichophytids," "epidermophytids" or merely "ids."

The frequency of mycotic involvement of the nails is I think not commonly appreciated. Fully one-fourth of all my patients presented gross lesions in the nails which were proven to be

*Read before the Florida East Coast Medical Association, St. Augustine, Nov. 1, 2, 1935.

mycotic or at least to contain mycelia and arthrospores upon examination in sodium hydrate. Many textbooks report onychomycosis as either unusual or infrequent and most of the included illustrations show lesions on the finger nails. I find the toe nails more frequently involved and can often demonstrate spores or mycelia from minor lesions on the nails when they are difficult to find elsewhere. Williams and Barthel reported a series of forty cases of tinea pedis in which they recovered fungous elements from the toe nails in every case.[6] My method consists in examining both the grumous material from beneath the nail and thin shavings from the hard but discolored portions of the nail either at the edge or from the dorsal surface. These can be quickly made with a sharp dental scaler and digested in 20% sodium hydroxide heating the slide very gently. The examination of the preparation requires a little experience but the differentiation of mycelia from cell outlines, extraneous cotton and silk fibers can soon be made. Mosaic figures are no longer considered as positive findings but represent intercellular cholesterol deposits.[7]

The introduction of skin tests to demonstrate cutaneous hypersensitivity to the fungi serves but little as an aid to diagnosis. Since so large a portion of the population have or have had some type of mycotic or yeast infection a positive test merely indicates that they have arrived at a state of sensitivity to the material injected. It obviously does not prove that the eruption under consideration is due to the organism from which the test product was elaborated. Moreover the test may be and frequently is negative, using the various commercial products now on the market when an active lesion containing mycelia is present. In such cases we postulate that we have not tested for the right strain of fungus, that it has not been present long enough to induce a state of allergy or else that it is growing as a saprophyte and causing no systemic reaction in the host. The experimental and allergic studies which have been made and which are being carried out have served to increase our knowledge of fungous diseases and have helped to explain many associated reactions. The studies are valuable contributions but it is my opinion that their worth both in diagnosis and treatment is yet to be evaluated and their indiscriminate use is to be condemned.

Mycologic studies of the fungi involved as causal agents has revealed that a large number of different species participate in the production of lesions which are morphologically the same. The identification and classification of the molds and yeasts is a highly specialized and time-consuming task requiring special training in mycology and is not to be attempted by the average laboratory worker. In the light of our present knowledge identification of the organisms which involve the hands and feet has not been of practical importance in the management or treatment of the condition. It has been shown many times that non-pathogenic molds and yeasts can be cultured from the normal skin and from lesions which are primarily due to other agents. The demonstration of spores or mycelia in the scale, crusts or nail is of greater significance than positive cultures in the average case and has the advantage of being both quicker and cheaper.

Ringworm eruptions on the hands and feet can be divided into three fairly well-defined groups from a clinical standpoint: 1. the intertrigenous group; 2. vesicular eruptions; 3. hyperkeratotic lesions. The first or intertrigenous is by far the most common particularly on the feet. The lesion may occur only between the fourth and fifth toes or may involve all the interdigital spaces and the trough beneath the toes. It is characterized by a moist, bluish-white, sodden epidermis which splits easily to form a fissure between the toes. Intertrigenous lesions are not common on the hands as the conditions which favor mycotic growth such as moisture and maceration are to a large extent absent. There is, however, a characteristic lesion of an intertrigenous type which occurs between the fingers and which travels under the sonorous title of erosio interdigitalis blastomycetica. It is a monilia infection, the causal organism closely resembling that which causes thrush. This condition is more common in women particularly those who have their hands often in dish water. It is reported as being common in orthodox Jewish women who do not use soap in washing dishes.[8] Monilia infections are also reported to be more common in diabetics. Before leaving the subject of monilia infections it is well to call attention to the paronychias, many of which are reported to be due to this organism. These are characterized by a painful bolster-like swelling of the entire nail fold most marked in the region of the lunula and tapering toward the finger tip. Pus may frequently be expressed from between the nail and the fold.

The problem of differential diagnosis should

not be difficult in the case of the intertrigenous group. One should not forget that staphylococci and streptococci may be the primary factor as well as the secondary invader. The frequency with which lymphangitis and lymphadenitis will occur with an intertrigenous lesion on the feet makes this assumption plausible. All such eruptions deserve at least one microscopic examination.

When the vesicular eruptions are considered, the problems of diagnosis are at once magnified for we must differentiate between actual vesicular lesions of mycotic disease, the secondary eruptions or "ids" which are often vesicular and the problem of the dyshidroses or functional vesicular eruptions. There are patients with a background of vasomotor instability who have repeated vesicular eruptions commonly confined to the hands but frequently involving the feet. They are characterized by multiple deep-seated, pinhead-sized vesicles which occur first along the edge of the fingers and in the beginning are intensely pruritic. Depending upon the severity of the reaction they may spread and extend to involve the dorsa and palms of the hands and the feet as well. The vesicles frequently become confluent and secondary pyogenic infection is common. As the reaction subsides in severe cases complete exfoliation of the epidermis may take place over the palms, soles, fingers and toes. Such patients are of course more likely to acquire a mycotic infection and the picture may be mixed. The nature and the background of such conditions has recently been presented and discussed by Becker.[9]

Another less common condition but one which must be at times considered is that reported by Andrews, Birkman and Kelly under the title of "Recalcitrant Pustular Eruption."[10] The eruption here begins as a deep-seated, pinhead-sized vesicle which very quickly becomes pustular. The pustules occur in groups but tend to remain discrete and as they approach the surface the overlying epidermis becomes a hard dry brown scale which is then exfoliated. These lesions begin on one hand or foot, frequently on the instep and the area gradually extends without any tendency to central involution and the other extremities are subsequently involved. The authors reported good results from the eradication of foci and consider the condition as a manifestation of focal infection but the majority of men who discussed the paper were not of this opinion. This condition closely resembles pustular psoriasis and acrodermatitis continua. It is resistant to local therapy for both ringworm and psoriasis and does not respond to roentgen therapy. I have recently verified this observation. The diagnosis of pustular psoriasis of the palms or soles in the absence of typical lesions elsewhere had best be left to the expert.

Other vesicular eruptions which occur in this location will suggest themselves. Contact dermatitis, drug eruptions, impetigo, etc., may present vesiculation but their course and evolution will readily distinguish them. Before the demonstration of fungi as a common cause of lesions on the hands and feet all vesicular eruptions on the palms and soles were called dyshidrosis or pomphylix and later they were all considered mycotic. Mitchell[11] in 1928 published a series of cases in which it was shown that the lesions were not mycotic. Some of the cases described resembled those reported by Andrews and his associates. Subsequently,[12] he reported five cases with detailed bacteriologic studies to prove that streptococcic infections in this location may simulate ringworm. This paper was published to protest the indiscriminate classification of all eruptions of the extremities as mycotic infections. His opinion should carry considerable weight since he published with Ormsby[13] one of the first papers in American literature on the subject.

The third or hyperkeratotic group is less common and offers fewer difficulties from a diagnostic standpoint. The skin on the palms or soles is thickened, yellowish and opaque and the process is of a more chronic type. Where the lesions extend around and onto the sides and dorsa of the foot it may present vesiculation or assume the appearance of a tineal infection on the glabrous skin with annular lesions. They may closely resemble certain annular tertiary lesions of syphilis or the late psoriasiform luetic lesions which are frequently seen on the hands. Occupational dermatitis and palmar and plantar hyperkeratoses of unknown etiology may be differentiated without great difficulty.

In a discussion of treatment it is only necessary to point to the large number of remedies which have been advised and devised to prove that none of them are universally successful. A great deal of careful work has been done and reported on the effectiveness of various fungicidal agents. It is also a fertile field for misinfor-

mation and proprietary remedies, none of which possess any advantage over the official preparations. The most satisfactory results are obtained by treating the condition according to the type and stage of the eruption which presents: in brief, the use of permanganate wet dressings and soaks for purulent and acutely inflamed stages, soothing applications for irritated eruptions and strong keratolytic and antifungicidal agents on the thickened indolent lesions. Crude coal tar, resorcin, salicylic acid, chrysarobin, mercurials, iodine, sulphur and thymol all have their place in treatment and no one method can be universally applied. Roentgen therapy has in my experience a limited value chiefly in the treatment of secondary changes which occur in long-standing cases such as lichenification. The occasional relief which it affords in acutely inflamed lesions is hard to evaluate but the symptomatic response may be valuable. It is ultimately successful only in conjunction with local therapy and is unnecessary in the management of most cases.

Treatment of the nails is not so hopeless as many think. The prognosis here depends entirely upon the extent of the involvement. Onychomycosis usually begins at the free margin and often at the lateral margin although it may be secondary to trauma. At any time before the matrix is involved a cure can usually be obtained by removal of the portion of the nail involved and appropriate local treatment. Following a suggestion offered by Dr. French of Miami I have used a dental burr to grind away the involved parts of the nail plate. If care is used it is painless and no anesthetic is necessary. When the matrix is involved avulsion of the nail is the only satisfactory method and recurrences cannot be prevented in every case even with the most diligent local treatment.

In conclusion I merely wish to state that while I consider fungous infections to be among the most common of skin diseases in this section, I feel that the diagnosis is made too frequently and with too little discrimination.

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THE EARLY HISTORY OF VACCINATION AGAINST SMALLPOX IN THE SOUTHEASTERN PART OF THE UNITED STATES. CORRECTIONS AND ADDITIONS

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In an article under the above title, published in this Journal in February, 1935 (Vol. XXI, No. 8, pp. 343-348), the writer made an error in stating that no account of the beginning of vaccination in this part of the country had come under his observation. The writer had seen years ago the account of the first vaccinations against smallpox in South Carolina, published by Dr. David Ramsay in the chapter on "Medical History," in the "History of South Carolina," but had forgotten it. The error was noted and a typed correction added before reprints were mailed. Since the conclusion in the article published in this journal was in agreement with the account in Ramsay's history, viz: that Dr. Ramsay was the first physician to perform vaccinations in South Carolina, no harm was done by this omission.

The writer wishes to correct another and more serious error and to express his regret for its occurrence. It was stated that no reference was made to the matter of the new method of protection against smallpox, by means of vaccination with cowpox, in the address to the South Carolina Medical Society, by Dr. Ramsay, entitled "A Review of the Progress of Medicine in the XVIIIth Century." The writer had seen a review of this address by Drs. Mitchill and Miller,

published in the Medical Repository (Vol. IV, 1801, pp. 390-399). This review seemed to be a complete review of the address, in which many pages, including several long paragraphs on the subjects of improvements in the treatment of smallpox, on the method of prevention by variolation were quoted verbatim, some portions of the address on other subjects being abstracted. The writer also made a mistake in the date of this address, which in the review was not dated, though the time was indicated in the full title.

Recently the writer has had the opportunity to see a copy of the original address of Dr. Ramsay, now a rare publication, and finds that it did contain a short, concise statement concerning vaccination with cowpox, and an endorsement ending with a statement grateful to the health officer: "The extermination of smallpox will be a necessary result."

The statement of the writer in regard to Dr. Ramsay's address was not intended to be critical. The thought of the writer was only that, at the time at which the address was supposed to have been delivered, no American observer would have been able to make an unqualified endorsement of vaccination. One year later the statement would not have applied.

Dr. Ramsay's address, with his endorsement of vaccination, made on January 1, 1801, after Waterhouse's application of the method in New England, was no doubt influential in bringing this subject to the attention of the physicians of Savannah who then, as now, had great regard for the professional ability, character, and scholarship of the great Charleston physician, patriot, and author.

After writing the above correction, I discovered another interesting fact concerning vaccination in Savannah:

In a book published by Dr. James Ewell, a physician of Savannah, the statement is made that Dr. Ewell introduced vaccination in Savannah in the year 1801, securing his vaccine from Thomas Jefferson of Virginia. It is well known that Jefferson took a great interest in vaccination, securing vaccine from Dr. Waterhouse of Boston. It is possible that this was the source of the vaccine used by Dr. Kollock. Much difficulty arose from the fact that vaccine rapidly deteriorated, especially in warm climates, and Jefferson devised a method of shipping virus in water-tight containers in order to keep it from being overheated.

Dr. Ewell's work on vaccination is noted in the biography of his life, printed in the tenth edition of Ewell's book, "The Medical Companion or Family Physician," by James Ewell, Physician in Washington, formerly of Savannah; Philadelphia, 1847, Thomas Cowperthwait & Company.

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YOUR POLITICAL RESPONSIBILITY

The "theme song" of the administration of the Florida Medical Association last year was politics.

It is encouraging to know that the present administration is also in favor of the physicians of the state becoming more politically minded. The President, in his visits to the various sections of the state is preaching the gospel of politics and is also presenting a plan whereby we, as a profession, can accomplish more in a political way.

Since our experience of last year, there should be no doubt in any physician's mind as to what our trouble was and what the remedy is.

When we consider that not one single recommendation made by the Florida Medical Association to the Governor of the State last year was accepted; when we consider that not one piece of legislation sponsored by the Florida Medical Association at the last legislature was made into law; when we consider that when we speak to candidates for office, we are asked, why should they listen to us, since only about 15% to 20% of our membership are registered voters, it is time for us as a body of good citizens to wake up to our responsibilities and to at least register, pay our poll tax and vote.

Are the dentists any better citizens than we are? They are practically all voters. They have the political situation well in hand. They make recommendations which are in turn accepted. They sponsor legislation and it becomes law. They are awake to their privileges and responsibilities. Their membership is about one-half of the number of ours. Are we ashamed of ourselves? We should be. Are the various cults better citizens than we are? They are registered voters. They can promise votes for favors and that is what it takes.

This is an election year. Does that mean anything to us? It should. However, it is not enough to merely talk politics. It is necessary for every member of our Association to register, to pay poll tax and to vote. That is your political responsibility.

The time is at hand when we must assert ourselves politically. We must become interested in the political well-being of our people as well as the political well-being of ourselves.

Our President is advocating the following plan which is already working in his home county:

A group is formed from the membership of the local medical, dental, pharmaceutical and nurses associations. However, this group acts freely and independently of any of these societies and is called "The Allied Political Health Council."

The purpose of this Council is to provide a medium for discussion and concerted action on matters of common interest to the licensed physicians, dentists, pharmacists and nurses. No one can become a member unless he be a member in good standing of his respective association and unless he be a registered voter.

The influence exerted in a community will be of inestimable value to the allied professions and, we feel, to the community at large. We in this way can make our influence felt throughout the state. Let every medical society in the state see that such a council is organized. Let every member of the State Association become a registered voter. Let us all become more politically minded. That is your political responsibility.

(Signed) HOMER L. PEARSON, M.D.

MODERN MEDICAL CARE

All of us are interested in our health and the health of those dear to us. During recent years a trend has developed toward preventive care. Much can now be accomplished in the prevention of disease. The story of diphtheria prophylaxis is well known. With universal application of our knowledge concerning this dread disease it would in a comparatively few years become a medical curiosity. The incidence of typhoid fever has been materially reduced since

the widespread use of prophylactic inoculations. Smallpox and tetanus are also controllable. Encouraging reports are accumulating to indicate that pertussis, a major pediatric problem, can be avoided. One can by proper measures determine susceptibility to other diseases and institute measures for their control.

The family physician holds a peculiar and enviable position of trust and confidence. His patients have learned that they can depend upon his wisdom and friendly counsel when danger threatens or illness occurs. This relationship of physician and patient is one that should be fostered. The patient also has a right to expect advice concerning proper precautionary measures to prevent disease. He is reassured to know that his doctor in whose ability he has respect and confidence is interested in helping him to remain well.

With modern progress in the practice of the healing art this question of preventive care is just one more responsibility that should be gladly assumed by the medical profession. We should not hesitate to advise concerning recognized methods of immunization, even though through lack of knowledge the patient has not solicited this advice.

HEART DISEASE

A comparatively short time ago pneumonia was generally known as the "captain of the men of death." However, pneumonia has since been displaced by heart disease which leads all causes of death in this country and bids fair to continue this leadership for an indefinite period of time.

One wonders why this increase in cardiac mortality? Is it because infectious diseases are more rampant; that, as a nation, we are more dissipated; that cardiac affections are recognized more readily; or that the tempo of life has increased to such an extent that the organ fails before its allotted time? Infectious diseases that cripple the heart, excepting rheumatic fever and syphilis, have decreased in frequency. The nation is certainly not more dissipated than it has ever been; in fact, the class of men whom cardiac disease affects dissipates less than the laboring class. Since the introduction of modern methods of cardiac diagnosis heart disease is diagnosed more readily. The average physician is becoming more "heart conscious" than ever before and is diagnosing cases that would have gone unrecognized years ago.

The average professional man is ambitious and strives to attain skill, success and financial security. Too often he does this at the expense of his health because he fails to remember that he is subject to the same diseases as his patients and is more susceptible to heart disease because of the life he leads.

It behooves every physician, if he is to render the best service to himself, family and patients, to take stock of himself and resolve that he will endeavor to systematize his work for the reward of those welcome hours of leisure and to realize that an annual vacation is a necessity. Too many physicians, snug in their fancied physical security, neglect themselves and die in their prime from degenerative heart disease.

Let the physician beware! He must realize that his own mode of living should be corrected. In doing this he will improve his efficiency and be able to take a real part in combating heart disease in his patients. Let the physician practice what he preaches.

1935 MEMBERSHIP

In this issue will be found the names of members of the Florida Medical Association whose annual dues to the Association have been paid for the year 1935. This official roster of our membership, which appears annually in the February Journal, is often used as a guide to a physician's professional standing or connection with organized medicine.

When a doctor fails to pay dues his name must necessarily be omitted from this membership roster. This is again called to the attention of those of our members who consider themselves officially connected with the organization but who have been negligent in paying their annual dues through the secretary of their county society.

At the last meeting of the House of Delegates the State was divided into six districts and provision made for selecting one member from each district to serve on the Executive Committee and the Committee on Scientific Work. This arrangement gives geographical representation on these two important committees. For the convenience of those who are interested and those who have the responsibility of making appointments by districts, it has been indicated on the following roster the geographical district in which each component society is located.

MEMBERSHIP ROSTER
FLORIDA MEDICAL ASSOCIATION
CALENDAR YEAR 1935

ALACHUA COUNTY MEDICAL SOCIETY (DISTRICT "B")

Maines, John E., Jr., President,
331½ W. University Ave.,
Gainesville
Dell, J. Maxey, 1st Vice-Pres.,
333 W. Main St., S.....Gainesville
Dailey, I. A., 2nd Vice-Pres. ..Micanopy
Merchant, Harry M., Sec'y-Treasurer,
124 E. University Ave...Gainesville
Anderson, James M.....Cross City
Andrews, Edwin H.,
208 W. Mechanic St.....Gainesville
Cobb, Alva T., Jr.,
Fla. Farm Colony.....Gainesville
Colson, J. H. .....Gainesville
Dell, J. Maxey,
333 W. Main St. So.....Gainesville
DePass, Matthew H.,
E. University Ave.....Gainesville
Elmore, W. T.,
Baird Bldg. .....Gainesville
Hodges, James H.,
234 E. Main St.....Gainesville
King, Seeber .....Lake Butler
Maines, John E. .....Lake Butler
Preston, H. F. .....Melrose
Raborn, John D.,
P. O. Box 145 .....Trenton
Smith, DeWitt T.,
Tucker Bldg. .....Gainesville
Snow, Thomas A.,
103 E. University Ave...Gainesville
Summerlin, J. L.,
1 Baird Bldg. .....Gainesville
Summitt, R. E.,
335 W. University Ave..Gainesville
Thomas, W. C. .....Gainesville
Tillman, G. C.,
505 W. University Ave., Gainesville
Willis, J. M. .....Williston
Young, Wm. Clement .....Chiefland

BAY COUNTY MEDICAL SOCIETY (DISTRICT "A")

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Panama City
Miller, Allen H., Sec'y-Treas., Millville
Adams, D. M., Jr.....Panama City
Bird, Terry .....Panama City
Fraser, Donald Scott.....Panama City
Middlebrooks, Wm. E. ....Panama City
Perkins, Herman .....Panama City
Whitfield, J. M.....Panama City

BREVARD COUNTY MEDICAL SOCIETY (DISTRICT "E")

Schlernitzauer, Bob, Sec'y-Treas.,
Rockledge
Bean, I. F. .....Melbourne
Chunn, J. D. .....St. Cloud
Counts, N. T. .....Cocoa
Creel, W. J. .....Eau Gallie
Hay, I. M.,
Melbourne Hospital .....Melbourne
Kenaston, T. C. .....Cocoa
Page, Walter C.,
317 Delannoy Ave.....Cocoa

BROWARD COUNTY MEDICAL SOCIETY (DISTRICT "F")

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915 Sweet Bldg. ....Ft. Lauderdale
Blount, Robt. E., Sec'y-Treas.,
360 S.E. 26th Ave...Ft. Lauderdale
Butler, Bruce F.,
206 Bank Bldg. .....Hollywood
Carter, Donald E.,
915 First Natl. Bank Bldg.,
Ft. Lauderdale
Connor, A. B.,
Sweet Bldg.....Ft. Lauderdale
Darrow, Anna A.,
310 S.E. 7th St. ....Ft. Lauderdale
Denniston, Frank,
616 Sweet Bldg. ....Ft. Lauderdale
Elliston, Leroy B.,
814 Sweet Bldg. ....Ft. Lauderdale
Elliston, Robt. L.,
810 Sweet Bldg. ....Ft. Lauderdale
Farringer, Robt. H.,
1666 Hollywood Blvd....Hollywood
Hamner, Geo. P.,
1st Hollywood Bk. Bldg., Hollywood
Harriss, R. R.,
Natl. Bk. Bldg. .....Hollywood
Hendricks, Elliott M.,
314 Sweet Bldg.....Ft. Lauderdale
McClellan, George S.....Pompano
McLaury, Elbert,
214-20 First Natl. Bk. Bldg.,
Hollywood
Mayhew, Royal H.,
2609 E. Las Olas Blvd.,
Ft. Lauderdale
Peavy, Henry J.,
505 F. N. B. Bldg., Ft. Lauderdale
Robinson, Leigh F.,
715 Sweet Bldg. ....Ft. Lauderdale
Roper, Luther Eldridge,
2011 Hollywood Bldg.....Hollywood
Skiff, Francis S.,
303 First Natl. Bk. Bldg.,
Ft. Lauderdale
Sory, Curtis H.,
616 Sweet Bldg. ....Ft. Lauderdale
Stovall, R. H.,
First Natl. Bk. Bldg., Ft. Lauderdale

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Box 707.....Lake City
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Ives, W. M.....Lake City
Nichols, Wm. S.,
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Lake City
Rose, Joseph,
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Washington, D. C.
Spearman, Mathew W.,
Morrison Bldg.....Lake City
Strickland, Henry M. .....Live Oak

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1409 Huntington Bldg.....Miami
Barge, H. A., Treasurer,
301-2 Olympia Bldg.....Miami
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903 Huntington Bldg.....Miami
Alexander, Julius,
301 Huntington Bldg. .....Miami
Allen, Omer F.,
711 Huntington Bldg.....Miami
Amerise, A. Daniel,
Coral Gables Clinic....Coral Gables
Aronovitz, Samuel,
705 Huntington Bldg.....Miami
*Babcock, Henry C.,
439 Ingraham Bldg.....Miami
Baker, Juel M.,
630 Seybold Bldg.....Miami
Baker, L. A.,
570 W. Flagler St.....Miami
Barfield, J. O.,
312 N. W. Third Ave.....Miami
Barge, W. J.,
442-3 Ingraham Bldg.....Miami
Batten, Glenn D.,
Jackson Mem. Hospital .....Miami
Bible, C. J.,
1203 W. Flagler St.....Miami
Black, Nelson M.,
703 Huntington Bldg.....Miami
Boughton, Herman,
441 Washington Ave...Miami Beach
Bowen, Carroll T.,
2622 S.W. 8th St. .....Miami
Browne, Van M. .....Hialeah
Brunner, E. C.,
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601 Huntington Bldg.....Miami
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P. O. Box 265, Lemon City..Miami
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1009 Huntington Bldg.....Miami
Day, George H.,
600 W. Flagler St.....Miami
DeBoe, Michael P.,
P. O. Box 505.....Miami
Deederer, Carleton,
300 Ingraham Bldg. .....Miami
Dees, John,
Ingraham Bldg.....Miami
DeVore, Louise,
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Dodge, Percy L.,
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Donald, Ernest,
805 Huntington Bldg .....Miami
Dunaway, Carl E.,
1209 Huntington Bldg.....Miami
Dunne, H. E.,
2985 S. W. 15th St.....Miami
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Lemon City .....Miami
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Huntington Bldg.....Miami
Elgin, Lee William,
330 Ingraham Bldg.....Miami
Ellis, Wm. Harrison,
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Eskew, Don C.,
800 N.E. 2nd Ave. .....Miami
Faver, R. Marshall,
127 N.E. 5th St. .....Miami
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Ingraham Bldg. .....Miami
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Foxworthy, F. W.,
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French, Elmo D.,
603 Huntington Bldg.....Miami
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809 Douglas Entrance, Coral Gables
Gammage, Tom Rogers,
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1715 S. W. 11th St.....Miami
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800 N.E. 2nd Ave. .....Miami
Gowdy, Francis A.,
419 Orange Ave. .....Ft. Pierce
Gowdy, Ralph A.,
809 Lincoln Rd. .....Miami Beach
Gowe, Donald F.,
N. E. 2nd Ave. & 36th St....Miami
Graves, J. Raymond,
709 Huntington Bldg. .....Miami
Grimes, Dewey H.,
P. O. Box 377.....South Miami
Haggard, William A.,
1101 Huntington Bldg.....Miami
Hall, E. J.,
201 Venetian Bldg.....Miami
Hall, John E.,
P. O. Box 2722 .....Miami

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Hardie, Dan., Jr.,
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Harris, David W.,
403 Huntington Bldg.....Miami
Harris, Robert M.,
1010 Huntington Bldg.....Miami
Hatch, Ernest Bruce,
71 N. E. 11th St.....Miami
Heck, Maurice E.,
125 N. E. 3rd St.,.....Miami
Hewlett, Frank W.,
202 LeBlond Bldg. ....Coral Gables
Hobbs, Laura Mae,
653 S. W. 2nd St.....Miami
*Hodges, John W.,
Gralynn Hotel .....Miami
Hodsdon, Benj. F.,
P. O. Box 923.....Miami
Hodsdon, L. A.,
418-20 Security Bldg.....Miami
Holmes, Albert G. H.,
414 N. E. 1st Ave.....Miami
Holmes, Roy J.,
601 Huntington Bldg. .....Miami
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541 Lincoln Road.....Miami Beach
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P. O. Box 1127.....Miami
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4022 Douglas Road.....Miami
Jenkins, Leslie M.,
712 Huntington Bldg.....Miami
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P. O. Box 35.....Miami Beach
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337 Lincoln Road.....Miami Beach
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Keeler, Frank L.,
1106 Huntington Bldg.....Miami
Kells, Paul,
430 Ingraham Bldg. .....Miami
Kemp, Austin J.,
207 Congress Bldg.....Miami
Kennon, Charles L.,
411 Huntington Bldg.....Miami
Kinsey, E. T.,
320 N.W. 7th Ave.....Miami
Kirsch, Maxwell D.,
408 Huntington Bldg. .....Miami
Kitchens, F. E.,
2506 Ponce de Leon Blvd.,
Coral Gables
Lanier, W. T.,
336 Ingraham Bldg. .....Miami
Laymon, R. L.,
300 Venetian Arcade Bldg....Miami
Leavitt, H. A.,
127 N. E. 5th St. .....Miami
Lefholz, Rothwell,
1009 Huntington Bldg.....Miami
Lewis, Taylor,
302 Congress Bldg.....Miami
Light, S. D. W.,
Ingraham Bldg.....Miami
Lithgow, William D.,
2200 Biscayne Blvd .....Miami
Litterer, A. B.,
309 Huntington Bldg.....Miami
Lott, Y. C.,
144 N. E. 2nd Ave.....Miami
Lowe, Eugene C.,
258 N. E. 21st St.....Miami
Lucinian, Joseph H.,
404 Huntington Bldg.....Miami
Lustgarten, A.,
1527 Washington Ave., Miami Beach
Lyell, Robert O.,
310 Huntington Bldg.....Miami
McClamrock, James M.,
410 Ingraham Bldg. .....Miami
McDonald, John T.,
312 Huntington Bldg.....Miami
MacDonell, Geo. N.,
P. O. Box 1861.....Miami
McGunagle, J. E.,
1885 W. Flagler St.....Miami
McKenzie, E. N.,
336 Ingraham Bldg.....Miami
McKenzie, Jack A.,
Huntington Bldg. .....Miami
McShane, James K.,
307 Ingraham Bldg.....Miami
Manson, Plumer J.,
8037 N.E. 2nd Ave. .....Miami
Marsh, Lucille J.,
812 Huntington Bldg. .....Miami
Martin, M. C.,
548 W. Flagler St.....Miami
Matthieu, Joseph,
3618 N.E. 2nd Ave. .....Miami
Maxwell, E. B.,
337 Lincoln Road.....Miami Beach
Medlin, Willard B.,
502 Security Bldg.....Miami
Mentzger, Claude,
2701 Biscayne Blvd. .....Miami
Milton, J. D.,
905 Huntington Bldg.....Miami
Moore, T. Earl,
24 S.W. River Drive.....Miami
Morrow, Frank R.,
1006 Huntington Bldg. .....Miami
Mosley, R. Sam,
Sun-Ray Park Health Resort, Miami
Nichol, E. Sterling,
305 Huntington Bldg.....Miami
Nichols, Frank O.,
37 N. W. 1st St.....Miami
Norton, Richard C.,
Battle Creek Sanitarium,
Miami Springs
O'Quinn, L. H. .....Hialeah
Otto, T. O.,
704 Huntington Bldg.....Miami
Owens, Duncan,
337 Lincoln Road.....Miami Beach
Palmer, Bascom H.,
502 Huntington Bldg.....Miami
Panettiere, Cayetano,
P. O. Box 227.....Miami Beach
Paulk, George A.,
202 Venetian Bldg.....Miami
Payton, Frazier J.,
Allison Hospital .....Miami Beach
Pearson, Homer L., Jr.,
1108 Huntington Bldg.....Miami
Pearson, John R.,
602 Olympia Bldg.....Miami
Pearson, Nelson T.,
1109 Huntington Bldg.....Miami
Pearson, Rufus J.,
Huntington Bldg.....Miami
Pepper, Max,
719 Seybold Bldg.....Miami
Perdue, Jean,
1213 Lincoln Road....Miami Beach
Perdue, John R.,
Ingraham Bldg. .....Miami
Perry, C. Larimore,
509 Huntington Bldg.....Miami
Peters, Edgar,
506 Olympia Bldg.....Miami
Phillips, Kenneth,
610 Huntington Bldg.....Miami
Pollock, Benjamin,
952 Collins Ave. .....Miami Beach
Preston, E.,
St. Francis Hospital...Miami Beach
Putnam, J. H.,
305 Huntington Bldg.....Miami
Quillian, Warren,
Coral Gables Clinic....Coral Gables
Raap, Gerard,
908 Huntington Bldg.....Miami
Reiss, Geo. L. .....Miami Beach
Rentz, L. S. .....Coconut Grove
Rentz, William C.,
3532 N. W. 17th Ave.....Miami
Repass, Robt. E.,
835 Lincoln Road ....Miami Beach
Richardson, James C.,
509 Olympia Bldg. .....Miami
Richardson, John R.,
Lincoln Road.....Miami Beach
Rinaman, James,
6043 N. E. 2nd Ave.....Miami
Roberts, Sam J.,
347-8 Ingraham Bldg. .....Miami
Roche, Chas. F.,
P. O. Box 483.....Miami Beach
Rogers, Hunter B.,
27 N. W. 12th Ave.....Miami
Roth, Edward,
901 Washington Ave., Miami Beach
Ryan, Harold A.,
Aladdin Medical Arts Bldg.,
Miami Beach
Sams, Wiley M.,
312 Ingraham Bldg.....Miami
Sayles, Chas. F.,
311 N. W. Third St.....Miami
Sayre, Robert F.,
76½ N.E. 1st St. .....Miami
Seeds, John B.,
544 W. Flagler St.....Miami
Shaw, E. Clay,
702 Huntington Bldg.....Miami
Shisler, J. W.,
409 Olympia Bldg. .....Miami
Silverman, Harry Z.,
760 Collins Ave.....Miami Beach
Skaggs, P. T.,
510 First Natl. Bk. Bldg.....Miami
Smith, C. Kirby,
210 E. Flagler St.....Miami
Smith, J. A. .....Homestead
Smith, J. W.,
1661 W. Flagler St.....Miami
Smith, Marvin,
405 Huntington Bldg.....Miami
Snyder, John Wm.,
402 Huntington Bldg.....Miami
Stewart, J. S.,
1105 Huntington Bldg.....Miami
Stuart, J. D.,
227 N. E. 5th St.....Miami
Tallman, M. H.,
1401 Huntington Bldg.....Miami
Thomas, Edwin C.,
46 N. E. 5th St. .....Miami
Thomas, Kelly C.,
318 N. W. 1st St.....Miami
Thomas, Merrick D.,
511 Meridian Ave., Miami Beach
Thomson, Wm. Ross.
835 Lincoln Road.....Miami Beach
Thorne, James I.,
300 Seybold Bldg. .....Miami
Threlkeld, Major Edgar,
Congress Bldg.....Miami
Tower, John B.,
32 N. Krome Ave.....Homestead
Tumlin, C. E.,
800 N.E. 2nd Ave. .....Miami
Turner, John C.,
Tatum Bldg.....Miami
Vinson, Willie J.,
400 Ingraham Bldg.....Miami
Vogt, Ferdinand A.,
Huntington Bldg. .....Miami
Voris, Frank B.,
St. Francis Hospital, Miami Beach
Walker, Harrison A.,
704 Lincoln Road.....Miami Beach
Walters, Arthur L.,
337 Lincoln Road.....Miami Beach
Watters, W. H.,
Boston-Miami Clinic, Coconut Grove
Weiland, Arthur H.,
227 Aragon Ave.....Coral Gables
Weinkle, Barney,
302 Huntington Bldg.....Miami
Welch, P. B.,
Huntington Bldg.....Miami
White, D. Ward,
1659 Washington Ave., Miami Beach
Whitten, Benj. L.,
P. O. Box 505.....Miami
Wilson, M. C.,
809 Huntington Bldg.....Miami
Withers, G. H.,
Aladdin Med. Arts Bldg.,
Miami Beach
Wood, Arthur W.,
401 Security Bldg.....Miami
Woodard, Robert C.,
Jackson Memorial Hospital..Miami
Wright, Sheffel,
315 Ingraham Bldg.....Miami
Youmans, Corren P.,
Veterans Hospital...St. Petersburg
Youmans, I. C.,
653 S. E. 2nd St.....Miami

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY (DISTRICT "D")

Kirkpatrick, Charles H., President,
P. O. Box 454 .....Arcadia
Spears, B. D.,
Vice-President .....Wauchula
Martin, Leldon W.,
Sec'y-Treasurer .....Sebring
Aurin, E. C. .....Ft. Ogden
Bevis, Henry P.....Arcadia
Brewster, Guy O. .....Sebring
Chandler, Isaac W.,
First Trust Bldg.....Avon Park
Eide, A. T. .....Lake Placid
Highsmith, G. F. .....Arcadia
Kayton, M. C. .....Wauchula
McKnight, George S.,
Jacaranda Arcade.....Avon Park
McSwain, Gordon H.....Arcadia
Peacock, W. H. .....Wauchula
Poucher, Allen A.....Wauchula
Pyatt, W. S. .....Bowling Green
Simmons, John A.....Arcadia
Simmons, S. J., Jr.....Belle Glade

* Deceased. † Honorary Member. § Life Member.

Touchton, W. C.....Avon Park
Weems, Howard V.,
22 Oak St. .....Sebring

DUVAL COUNTY MEDICAL SOCIETY (DISTRICT "C")

Sellers, E. T., President,
412 St. James Bldg....Jacksonville
Woolsey, B. F., Vice-President,
320 St. James Bldg....Jacksonville
Mabry, Chas. B., Secretary,
202 Medical Arts Bldg., Jacksonville
Hayes, J. W., Treasurer,
309 Professional Bldg., Jacksonville
Adams, George E.,
2017 Main St.....Jacksonville
Alford, Neil,
St. James Bldg.....Jacksonville
Arms, B. L.,
P. O. Box 353....Farmington, Me.
Baker, R. M.,
Professional Bldg.....Jacksonville
Baumgartner, Carl J.,
406 Masonic Bldg.....Jacksonville
Bayless, W. C.,
202 St. James Bldg....Jacksonville
Beckman, George E.,
Professional Bldg.....Jacksonville
Black, J. B.,
St. James Bldg.....Jacksonville
Boone, James L.,
500 Professional Bldg, Jacksonville
Borland, J. L.,
2033 Riverside Ave.....Jacksonville
Bransford, L. E.,
Professional Bldg.....Jacksonville
Brink, Fritz A.,
3804 Valencia Road ...Jacksonville
Brinson, P. A.....Baldwin
Brinson, W. D.....Baldwin
Broadbent, Oliver P.,
454 St. James Bldg.....Jacksonville
Brown, Alan DeWitt,
417 St. James Bldg....Jacksonville
Bryant, James M.,
303 Medical Arts Bldg., Jacksonville
Buckman, Thomas E.,
1022 Park St.....Jacksonville
Carefoot, E. I.,
Professional Bldg.....Jacksonville
Cason, Turner Z.,
2033 Riverside Ave.....Jacksonville
Chapman, Benjamin A.,
2151 Pearl St.....Jacksonville
Chilli, Joseph L.,
401 St. James Bldg. ...Jacksonville
Copeland, Silas M.,
203 St. James Bldg.....Jacksonville
Copp, F. A.,
458 St. James Bldg....Jacksonville
Counts, H. W.,
312 Peninsular Life Bldg,
Jacksonville
Croft, George W.,
St. James Bldg.....Jacksonville
Croft, Theo. G.,
713 Greenleaf Bldg. ...Jacksonville
Cunningham, Lester W.....Mandarin
Day, Gaston,
310 W. Church St.....Jacksonville
Dean, Russell,
St. James Bldg.....Jacksonville
Drew, Horace R.,
St. James Bldg.....Jacksonville
Driskell, Simon E.,
458 St. James Bldg.....Jacksonville
Dyrenforth, Lucien Y.,
P. O. Box 2098, W. Bay Annex,
Jacksonville
Eaton, Paul,
2835 Selma St. .....Jacksonville
Erwin, Stanley,
1001 Lynch Bldg.....Jacksonville
Field, Thomas S.,
712 Laura St.....Jacksonville
Fort, Frank L.,
201 Medical Arts Bldg..Jacksonville
Gammon, Julian E.,
700 Professional Bldg...Jacksonville
Goodale, Banks H.,
St. James Bldg.....Jacksonville
Gorman, John M.,
318 St. James Bldg....Jacksonville
Greene, Ralph N.,
Medical Arts Bldg.....Jacksonville
Gurganious, Allen P.....Palatka
Hanson, Henry.
3827 Ortega Blvd. .....Jacksonville
Harrell, D. E.,
St. James Bldg.....Jacksonville
Harrell, O. E.,
St. James Bldg.....Jacksonville
*Harris, Herrman H.,
608 Greenleaf Bldg.....Jacksonville
Harris, W. G.,
St. James Bldg.....Jacksonville
Hartman, James H.,
546 Lomax St.....Jacksonville
Henley, Charles F.,
412 St. James Bldg. ...Jacksonville
Henson, Graham E.,
201 St. James Bldg.....Jacksonville
Holden, Gerry R.,
Medical Arts Bldg.....Jacksonville
Holloway, Luther W.,
359 St. James Bldg....Jacksonville
Horne, Hendley F.,
325 W. Duval St.....Jacksonville
Hughes, V. A.,
302 St. James Bldg....Jacksonville
Humphreys, David G.....Fernandina
Ira, Gordon H.,
452 St. James Bldg.....Jacksonville
Jelks, Edward,
Riverside Hospital.....Jacksonville
†Jennings, C. L.,
General Delivery, Winnsboro, S. C.
Johnston, Crowell W.,
355 St. James Bldg.....Jacksonville
Keisling, Frederick C.,
315 Professional Bldg., Jacksonville
Killinger, Raymond R.,
St. James Bldg.....Jacksonville
Kirby-Smith, Joseph L.,
1115 Greenleaf Bldg....Jacksonville
Kirk, Wm. Wilson,
608 Greenleaf Bldg.....Jacksonville
Klein, Lawrence A.,
810 Greenleaf Bldg....Jacksonville
Knauer, W. Jerome,
Buckman Bldg.....Jacksonville
Knight, A. Comer,
Professional Bldg.....Jacksonville
Krueger, Frederick W.,
452 St. James Bldg....Jacksonville
Laffitte, L. Sydnor,
Medical Arts Bldg.....Jacksonville
Limbaugh, Louie M.,
357 St. James Bldg....Jacksonville
Lyerly, J. G.,
1022 Park St. .....Jacksonville
McDaniel, R. L.,
1855 Laura St.....Jacksonville
McEuen, H. Bernard,
320 Professional Bldg...Jacksonville
McGinnis, Robert H.,
2063 Oak St.....Jacksonville
McIver, Robert B.,
Greenleaf Bldg. .....Jacksonville
Mandoza, Carl C.,
345 St. James Bldg.....Jacksonville
Manhoff, Ben,
712 Laura St.....Jacksonville
Manning, Wm. S.,
310 Greenleaf Bldg....Jacksonville
Martin, P. H.,
Professional Bldg.....Jacksonville
May, Robert D.,
302 Professional Bldg..Jacksonville
Milam, Ernest B.,
Medical Arts Bldg.....Jacksonville
Mitchell, George M.,
712 Laura St.....Jacksonville
Mitchell, John H.,
300 Professional Bldg...Jacksonville
Moe, Leonard N.,
212 St. James Bldg....Jacksonville
Morris, Kenneth A.,
237 W. Duval St.....Jacksonville
Morris, S. A.,
237 W. Duval St.....Jacksonville
Norris, Samuel R.,
Medical Arts Bldg.....Jacksonville
Norwood, J. K.,
211 St. James Bldg.....Jacksonville
Oberdorfer, Aaron Z.,
409 St. James Bldg.....Jacksonville
Oetjen, G. F.,
211 E. Forsyth St.....Jacksonville
Owens, J. H.,
1855 Laura St.....Jacksonville
Palmer, Thomas M.,
2030 Park St. .....Jacksonville
Parramore, James B.,
401 St. James Bldg.....Jacksonville
Pasco, J. D.,
Medical Arts Bldg.....Jacksonville
Peterson, C. A.,
St. James Bldg. .....Jacksonville
Peyton, Harry A.,
2033 Riverside Ave.....Jacksonville
Porter, H. W.,
340 St. James Bldg.....Jacksonville
Quasser, Adolph B.,
352 St. James Bldg....Jacksonville
Ramage, Raymond B.,
219-20 Professional Bldg.,
Jacksonville
Randolph, J. H.,
St. James Bldg.....Jacksonville
Richards, Ferdinand,
1022 Park Street.....Jacksonville
Richardson, George W.,
343 St. James Bldg....Jacksonville
Richardson, Shaler,
111 W. Adams Street..Jacksonville
Roberts, Earl.....Jacksonville Beach
Rogers, W. W.,
Professional Bldg.....Jacksonville
Rollins, Clarence D.,
Southside General Hospital.
45 W. Miami Road, S. Jacksonville
Ross, William E.,
St. James Bldg.....Jacksonville
Royce, Clayton E.,
P. O. Box 2098, W. Bay Annex,
Jacksonville
Safer, Jacob V.,
452 St. James Bldg.....Jacksonville
Sanderson, Raymond,
216 Professional Bldg...Jacksonville
Sandusky, C. M.,
28 W. Monroe St.....Jacksonville
Schnauss, Fauntleroy H,
318 Hildebrandt Bldg., Jacksonville
Schnauss, William R.,
312 Hildebrandt Bldg...Jacksonville
Sengstak, Ernst P. E.....Mandarin
Shaw, W. M.,
St. James Bldg.....Jacksonville
Simpson, J. Knox,
712 Laura St.....Jacksonville
Slaughter, Frank G.,
Riverside Hospital ....Jacksonville
Stollenwerck, A. D.,
2005 Oak St.....Jacksonville
Strumpf, Irving J.,
344 St. James Bldg....Jacksonville
Swift, Edwin C.,
1022 Park St.....Jacksonville
Taylor, H. Marshall,
111 W. Adams St.....Jacksonville
Thomas, Robert Y. H.,
502-6 Lynch Bldg. .....Jacksonville
Thompson. David C. .....Azucar
Tyler, Lockland V.,
San Marco Square, So. Jacksonville
Upchurch, Noble A.,
City Board of Health..Jacksonville
Van Schaick, Harold D.,
210 St. James Bldg....Jacksonville
Veal, Ernest W.,
128 St. Johns Ave...So. Jacksonville
Waas, Frederick J.,
Professional Bldg.....Jacksonville
Washburn, Clayton D.,
St. James Bldg.....Jacksonville
Wilcox, Clarence R.,
712 Laura St.....Jacksonville
Wilkinson, Albert H.,
313 Professional Bldg., Jacksonville
Wilson, Alpheus K.,
334 St. James Bldg....Jacksonville
Wynn, Robert S.,
305 Consolidated Bldg..Jacksonville

ESCAMBIA COUNTY MEDICAL SOCIETY (DISTRICT "A")

Lischkoff, M. A., President,
Blount Bldg. .....Pensacola
Gachet, Necy L.,
Vice-President .....Century
Hoffman, James M., Sec'y-Treasurer,
6 W. Chase St.....Pensacola
Ames, Allen M.,
206 Blount Bldg.....Pensacola
Anderson, Warren E.,
511 American Natl. Bk. Bldg.,
Pensacola
Bell, John D.,
505 Blount Bldg.....Pensacola
Blackshear, T. E.,
406-8 Amer. Natl. Bk. Bldg.,
Pensacola
Born, Charles C.,
513 Blount Bldg.....Pensacola
Bryans, Herbert L.,
21½ E. Wright St.....Pensacola
Daniels, J. P.,
321-3 Brent Bldg. .....Pensacola
Dodson, M. W.,
P. O. Box 57.....Alaflora, Ala.
Fellows, J. H.,
Brent Bldg. .....Pensacola
Fisher, Luther C., Jr.,
513 Amer. Natl. Bk. Bldg.,
Pensacola

* Deceased. † Honorary Member. § Life Member.

Haisfield, A. R.,
311 Blount Bldg.....Pensacola
Haisfield, H. B.,
311 Blount Bldg.....Pensacola
Heinberg, Chas. J.,
506 Blount Bldg. .....Pensacola
Hogan, C. M.,
Theisen Bldg. .....Pensacola
Holley, John C. .....Milton
Kennedy, S. G.,
511-12 Am. Natl. Bk. Bldg.,
Pensacola
McGuire, J. J.,
Pensacola Hospital.....Pensacola
McLane, J. N.,
204 W. Brainard St.....Pensacola
McSween, J. C. .....Pensacola
Mock, A. E.,
211 Blount Bldg. .....Pensacola
Nobles, R. G.,
Blount Bldg.....Pensacola
Nobles, V. R.,
Blount Bldg.....Pensacola
Nobles, W. D.....Pensacola
Payne, W. C.,
Blount Bldg. .....Pensacola
§Pierpont, Juriah H.,
511 American Bk. Bldg., Pensacola
Quina, M. E.....Pensacola
*§Renshaw, F. G.,
104 S. Palafox.....Pensacola
Stokes, Thos. H.,
Theisen Bldg. .....Pensacola
Sullivay, Rosa L.,
1016 W. Chase St.....Pensacola
Thames, J. G. .....Milton
Thames, Rufus .....Milton
Turberville, J. I.....Century
Turberville, John S.....Century
Turner, John B. .....Bagdad
Webb, Carol C.,
303 Blount Bldg.....Pensacola
White, Alvyn W.,
P. O. Box 1345 .....Pensacola

HILLSBORO COUNTY MEDICAL SOCIETY (DISTRICT "D")

Bottari, Giulio C., President,
1425½ E. Broadway.....Tampa
Blake, William C., Vice-President,
412 Citizens Bank Bldg.....Tampa
Helms, John S., Jr., Sec'y-Treasurer,
P. O. Box 1439.....Tampa
Adamson, William P.,
610 Citizens Bank Bldg.....Tampa
*Allen, Bundy,
302 Citizens Bank Bldg.....Tampa
Alsobrook, John W.,
120 N. Collins St.....Plant City
Andrews, Chadbourne A.,
715 Citizens Bank Bldg.....Tampa
Austin, Edgar .....Plant City
Barker, Frank T.,
302 Krause Bldg.....Tampa
Bartlett, Charles W., Jr.,
310 First Natl. Bk. Bldg.....Tampa
Beyer, A. R.,
P. O. Box 527.....Tampa
Bidwell, Alfred M.,
401 First Natl. Bk. Bldg.....Tampa
Bitzer, Emory W.,
815 Citizens Bank Bldg.....Tampa
Black, Robert C.,
101 San Ever St.....Plant City
Blackmon, H. J.,
Citizens Bank Bldg.....Tampa
Boling, John R.,
1207-11 First Natl. Bk. Bldg..
Tampa
Bradshaw, Virgil M.,
316 Citrus Exchange Bldg..Tampa
Brown, G. W., Jr.,
506 Exchange Bank Bldg.,
Tallahassee
Brown, Harold O.,
215 Madison St.....Tampa
Butchart, T. R.,
804 Grand Central Ave.....Tampa
Carlton, Leland F.,
805 Citizens Bank Bldg.....Tampa
Carter, E. F.,
1903 Grand Central Ave.....Tampa
Chandler, J. C.,
410 Citrus Exchange Bldg..Tampa
Coleman, John A.,
105 N. Collins St. .....Plant City
Cook, George L.,
906 So. Rome Ave.....Tampa
Cook, H. M.,
107 Parker St.....Tampa
Costa, F. J.,
Centro Austuriano Hosp.....Tampa
Cowart, J. T.,
1111 Citizens Bank Bldg. ...Tampa
Crum, James W.,
413 Central Office Bldg.....Tampa
Dickinson, J. C.,
302 Citizens Bank Bldg.....Tampa
Dominguez, J. A.,
P. O. Box 5745 .....Tampa
Draper, Arthur D.,
5607 Florida Ave. .....Tampa
Duke, Roncie R.,
708 Citizens Bank Bldg.....Tampa
Duncan, William P.,
802 Tampa Theatre Bldg.....Tampa
Dyer, Walter H.,
1801½ 22nd St. .....Tampa
Efird, Lester J.,
1019 W. Platt St.....Tampa
Ely, R. A.,
404½ Zack St.....Tampa
Estes, J. L.,
815 First Natl. Bk. Bldg.....Tampa
Etheredge, S. H.,
706 Franklin St.....Tampa
Faver, Henry M.,
205 Zack St. .....Tampa
Ferlita, Americo J.,
2512 15th Ave. .....Tampa
Ferrante, G. C.,
205 Zack St. .....Tampa
Forbes, Sherman B.,
409 Citizens Bank Bldg.....Tampa
Garcia, Parsons M.,
P. O. Box 7224 .....West Tampa
Gilbert, Elsie,
6508 Central Ave.....Tampa
Gilmer, Eugene S.,
416 Citizens Bk. Bldg.....Tampa
Gonzalez, A. A.,
1725½ Seventh Ave.....Tampa
Grable, James S.,
822 Citizens Bank Bldg.....Tampa
Grantham, James M.,
442 Lafayette Arcade.....Tampa
Grimal, A. S.,
P. O. Box 5745 .....Tampa
Guerra, Julio J.,
First Natl. Bk. Bldg.....Tampa
Gyland, Stephen P.,
215 Madison St.....Tampa
Halton, Jack,
P. O. Box 1337.....Sarasota
Hardy, G. E. W.,
818 First Natl. Bk. Bldg.....Tampa
Henderson, Robert P.,
215 Exchange Bldg. .....Orlando
Higgins, Allen F.,
442 W. Lafayette St.....Tampa
Holloway, E. W.,
205 7th Ave. .....Tampa
Holton, W. J.,
119 E. Reynolds St. ....Plant City
Hopkins, C. D.,
1818 Hills Ave. .....Tampa
Jefferson, Rollin,
818 First Natl. Bk. Bldg....Tampa
Jensen, H. J.,
7303 Nebraska Ave.....Tampa
Jobson, A. M. C.,
702 Citizens Bk. Bldg.....Tampa
Knauf, A. R.,
706 Franklin St.....Tampa
Knight, John C.,
121 N. Collins St.....Plant City
Lake, Esley T.,
P. O. Box 8968.....Tampa
Lancaster, Wm. J...Wilmington, N. C.
Lowry, Blackburn W.,
408 Citrus Exchange Bldg...Tampa
McClosky, B. Martin,
1801½ 22nd St.....Tampa
McEachern, J. R.,
P. O. Box 2214.....Tampa
Maguire, Thomas C.,
104 S. Collins St.....Plant City
Maner, George R.,
5309 Central Ave. .....Tampa
Martin, Douglas D.,
906 So. Rome Ave.....Tampa
Martorell, Abelardo,
215 Madison St. .....Tampa
Meighen, Douglas G.,
Citrus Exchange Bldg.....Tampa
Metzger, Frank C.,
916-17 Citizens Bk. Bldg.....Tampa
Mills, Herbert R.,
706 Franklin St.....Tampa
Mills, John H.,
907 17th Ave. .....Tampa
Minardi, Joseph A.,
2203½ Seventh Ave.....Tampa
Mitchell, L. B.,
P. O. Box 1020.....Tampa
Mols, Edith P.,
Citizens Bank Bldg.....Tampa
Moore, John T.,
317 Tribune Bldg.....Tampa
Murphey, David R., Jr.,
611 Citizens Bldg. .....Tampa
Myers, Wade C.,
302 Schulte-United Bldg.....Tampa
Nelson, Robert G.,
712 Citizens Bank Bldg.....Tampa
†Oppenheimer, Louis S.,
108 Crescent Place.....Tampa
Ortega, Rafael,
P. O. Box 5513, Ybor Sta...Tampa
Paniello, Santiago,
P. O. Box 5105, Ybor Sta...Tampa
Pate, Julien C.,
1107 First Natl. Bk. Bldg....Tampa
Patterson, William,
312 Citrus Exchange Bldg...Tampa
Pease, Charles W.,
State Board of Health.....Tampa
Porro, Gustavo F.,
1915½ 14th St. .....Tampa
Portocarrero, N. A.,
1915½ 14th St.....Tampa
Rankin, Grover C.,
P. O. Box 1313.....Tampa
Rector, Lee T.,
Citizens Bank Bldg.....Tampa
Roig, Guillermo,
2710 Nebraska Ave. .....Tampa
Powlett, W. M.,
P. O. Box 786 .....Tampa
Rudisill, C. A.,
706 Franklin St.....Tampa
Sanchez, Butler H.,
15-17 Lee Bldg. .....Plant City
Saxton, J. J.,
315 Citrus Exchange Bldg...Tampa
Scolaro, Joseph D.,
202¼ 7th Ave., Ybor City, Tampa
Shaver, E. F.,
Tampa Theatre Bldg.....Tampa
Smith, H. Mason,
903 Tampa Theatre Bldg....Tampa
Smoak, Edward,
315 Citizens Bank Bldg.....Tampa
Snow, H. O.,
1903 Grand Central Ave.....Tampa
Spengler, Nathaniel L.,
903 Tampa Theatre Bldg.....Tampa
Spoto, Joseph S.,
1829½ E. Broadway.....Tampa
Stone, Alvord L.,
102 E. Hillsboro Ave.....Tampa
Stringer, Sheldon,
P. O. Box 105 .....Tampa
Taylor, Joseph W.,
706 Franklin St.....Tampa
Torbett, R. S.,
409 First Natl. Bk. Bldg.....Tampa
Torretta, Joseph N.,
2823 Nebraska Ave.....Tampa
Truelsen, Thomas,
Room 605, 706 Franklin St...Tampa
Vaughan, Cecil,
228 Lafayette Arcade.....Tampa
Vinson, J. C.,
215 Madison St. .....Tampa
Weekley, Augustine S.,
416 Citrus Exchange Bldg., Tampa
Winton, M. R.,
402 Citrus Exchange Bldg...Tampa

INDIVIDUALS

†Anderson, Thomas S.,
P. O. Box 127.....Live Oak

JACKSON COUNTY MEDICAL SOCIETY (DISTRICT "A")

Box, C. C., President.....Graceville
Price, C. J.,
Vice-President .....Alford
Pierce, J. Lewis, Sec'y-Treasurer,
Marianna
Baltzell, N. A.....Marianna
Burns, M. Q.....Blountstown
Dowling, J. B.....Alliance
Hodges, G. S. .....Marianna
McKinnon, Daniel A.....Marianna
Miller, Redden L.,
P. O. Box 186.....Graceville
Ryals, C. H.,
R. F. D. No. 1.....Grand Ridge
Whitaker, C. D.,
Dekle Bldg. .....Marianna

* Deceased. † Honorary Member. § Life Member.

LAKE COUNTY MEDICAL SOCIETY (DISTRICT "E")

Coupland, Jas. D., President.....Eustis
Williams, Rabun H., Vice-President,
Theatre Bldg. .....Eustis
Ashton, W. Lee, Sec'y-Treasurer,
Umatilla
Bowen, Louis R.,
P. O. Box 905.....Eustis
Coleman, E. M.....Groveland
Colley, Sanford C. .....Tavares
Conklin, Raymond C.,
141 W. 6th Ave.....Mount Dora
DeVane, W. G. .....Groveland
Fenn, Harry T.....Mount Dora
Hannum, M. M.....Eustis
Hawkins, A. S.,
779 Montrose St.....Clermont
Holland, Howard G.,
1112 W. Main St.....Leesburg
Morrison, Harry K.,
601 W. Magnolia.....Leesburg
Oetjen, Leroy H.,
1028 W. Main St. .....Leesburg
Strickland, Edgar E. .....Mt. Dora
Toy, Samuel H.....Umatilla
Tyre, C. McK.....Eustis
Wood, Will L. .....Mt. Dora

LEE COUNTY MEDICAL SOCIETY (DISTRICT "D")

Bostelman, Ernest, President,
201 Pythian Bldg. .....Ft. Myers
Grace, William H., Vice-President,
15 Earnhardt Bldg. .....Ft. Myers
Jones, H. Quillian, Sec.-Treasurer,
18-20 Leon Bldg. .....Ft. Myers
Bartleson, Fred .....Ft. Myers
Harrison, Warren A.,
6th & Shelby St. ....Bristol, Tenn.
Johnson, M. F.,
2045 Hendry St. .....Ft. Myers
Longbrake, Guy A.,
308 Second St.....Ft. Myers
Merrick, C. Gordon,
26 Leon Bldg.....Ft. Myers
Newton, Robley D.,
5-6 Earnhardt Bldg. .....Ft. Myers
Whisnant, Baker,
3 Leon Bldg.....Ft. Myers

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY (DISTRICT "A")

Johnston, John K., President,
Exchange Bldg. .....Tallahassee
Godsrd, Robt. F., Vice-President,
Key Bldg. .....Quincy
Kendrick, Odis G., Sec'y-Treasurer,
Tallahassee
Barnes, Benjamin F.....River Junction
Beggs, John M.,
Fla. State Hospital..Chattahoochee
Brevard, Ephraim M.,
Lively Corner.....Tallahassee
Brinson, John B., Jr.,
Dogwood St.....Monticello
Conter, A. E. .....Apalachicola
Daves, F. E. .....Chattahoochee
Davis, Julius C.,
203-8 Masonic Bldg. .....Quincy
Dozier, L. L.....Tallahassee
Dykes, Chapman .....Carrabelle
Graves, L. J.,
P. O. Box 623.....Tallahassee
Gwynn, Geo. H., Jr.,
Telephone Bldg. .....Tallahassee
Howell, Harry S. .....Chattahoochee
Jenkins, O. W. .....Chattahoochee
McClure, Herbert A.,
State Board of Health Bldg.,
Tallahassee
Massey, William W.,
Davidson Bldg. .....Quincy
Moor, F. Clifton,
Telephone Bldg.....Tallahassee
Palmer, Henry E.,
408 S. Adams St.....Tallahassee
Pound, J. H. .....Chattahoochee
Rhodes, Bricey M.,
121 E. College Ave. ...Tallahassee
Robertson, J. C. .....Chattahoochee
Salley, S. Marion,
440 Ingraham Bldg. .....Miami
Wilhoit, Sterling E.....Quincy
Wilkinson, B. A.,
Telephone Bldg.....Tallahassee
Williams, J. F.....Monticello
Williams, John L.....Tallahassee

MADISON COUNTY MEDICAL SOCIETY (DISTRICT "B")

Long, Eustace, President.....Madison
Davis, George O.,
Sec.-Treasurer .....Madison
Thorpe, E. D. .....Madison

MANATEE COUNTY MEDICAL SOCIETY (DISTRICT "D")

Gates, Hubbard, President,
P. O. Box 245 .....Bradenton
Mason, John F.,
Vice-President .....Bradenton
Sugg, William D., Sec'y-Treasurer,
Bradenton Bank Bldg....Bradenton
Blake, Lowrie W.....Bradenton
Floyd, A. J.....Palmetto
Hollingsworth, Samuel G.,
451 Twelfth St.....Bradenton
Lancaster, B. M. .....Manatee
Larrabee, Chas. W.,
Larrabee Hospital .....Bradenton
McDuffee, Toliver M.....Manatee

MARION COUNTY MEDICAL SOCIETY (DISTRICT "B")

Chalker, James L., President,
719 E. Ocklawaha Ave.....Ocala
Moore, J. N., Vice-President,
210-12 Prof. Bldg. .....Ocala
Cumming, Richard C., Sec'y-Treasurer,
Commercial Bank Bldg.....Ocala
Cammack, K. R.....Gulf Hammock
Dozier, Henry C.,
9 N. Magnolia St.....Ocala
Ferguson, R. D.,
P. O. Box 802 .....Ocala
Freeman, Albert H.,
Holder Block.....Ocala
Gatrell, Henry .....Fairfield
†Hood, J. W.....Ocala
Lindner, E. G.....Ocala
Lisk, Percy F.....Ft. McCoy
Lytle, Carl S. .....Dunnellon
Martin, Irl E.,
800 N.E. 2nd Ave. .....Miami
Mathews, A. L.,
CCC Camp .....Sarasota
Mimms, Carney W.,
Commercial Bank Bldg. .....Ocala
Peek, Eugene G.,
Commercial Bank & Trust Bldg.,
Ocala
Russell, Ralph E.....Ocala
Slaughter, T. K. .....Wildwood
Strange, J. L.....McIntosh
Wallis, Thomas H.,
104 S. Magnolia St. .....Ocala
Watt, Harry F.,
P. O. Box 146.....Ocala

MONROE COUNTY MEDICAL SOCIETY (DISTRICT "F")

Galey, Harry C., President,
532 Fleming St. .....Key West
Pintado, Nilo C., Vice-President,
333 Duval St. .....Key West
Warren, William R., Sec'y-Treasurer,
511 Eaton St.....Key West

ORANGE COUNTY MEDICAL SOCIETY (DISTRICT "E")

Rivers, Thos. M.,
President .....Kissimmee
Sinclair, W. E., Vice-President,
Clinic Bldg. .....Orlando
Pines, John A., Secretary,
106-110 E. Central Ave.....Orlando
Day, Horace A., Treasurer,
209-12 Exchange Bldg.....Orlando
Anderson, Claude,
1400 E. Church St. .....Orlando
Andrews, Mitchell M.,
P. O. Box 1817 .....Orlando
Beardall, Harold M.,
147 E. Church St.....Orlando
Brame, Dorothy D.,
316-18 Exchange Bldg.....Orlando
*Brinson, Haynes .....Kissimmee
Buff, Julian H.,
49 N. Orange Ave.....Orlando
Burks, B. Auxford,
108 E. Park Avenue...Winter Park
Butler, Paul T.,
23 Autrey Arcade.....Orlando
Calvert, Read N.,
Wash. Sanit. & Hosp.,
Washington, D. C.
Chappell, John R.,
P. O. Box 1370 .....Orlando
Chiles, J. H.,
P. O. Box 943.....Orlando
Christ, Calvin D.,
P. O. Box 1137.....Orlando
Collins, Chas. J.,
209-12 Exchange Bldg. ....Orlando
Dodds, William H.,
11th St. & Pa. Ave.....St. Cloud
Ermshar, Herman F.,
Wash. Sanit. & Hosp.,
Washington, D. C.
Folsom, Spencer A.,
11 Lucerne Circle.....Orlando
Gardner, J. F. .....Winter Park
Gray, Frank D.,
311-12 Exchange Bldg. ....Orlando
Gwathmey, G. Tayloe,
710 Fla. Bank Bldg.....Orlando
Gwynn, Humphrey W.,
Clinic Bldg.....Orlando
Harms, F. H.,
64 N. Court St. .....Orlando
Hart, Ruth S. .....Winter Park
Hoffmann, Carl D.,
25-27 Autrey Arcade .....Orlando
Hotard, Roland F.,
226 E. Park Ave.....Winter Park
Ingram, L. C.,
P. O. Box 1711.....Orlando
†Johnston, Colonel Geo. C.,
P. O. Box 272.....Orlando
Johnston, Hewitt,
P. O. Box 2002 .....Orlando
Lawrence, E. J. .....Winter Garden
Lawson, Ben Hill.....Winter Garden
Lewis, P. M.,
P. O. Box 346 .....Orlando
Lynn, C. W.,
Fla. Sanitarium.....Orlando
McBride, Thomas E.....Apopka
McEwan, Duncan T.,
106-10 E. Central Ave.....Orlando
McEwan, John S.,
106-10 E. Central Ave....Orlando
Mallory, Meredith,
P. O. Box 1011.....Orlando
Morton, B. Rosalie S.....Winter Park
Neal, Thomas A.,
P. O. Box 321 .....Orlando
Oertel, H. B. .....Willow
Orr, Louis McD.,
311 Exchange Bldg.....Orlando
Osincup, Gilbert S.,
300 E. Colonial Drive.....Orlando
Page, W. Grady,
State Bank Bldg.....Orlando
*†Person, W. C.,
258 S. Main St.....Orlando
Redding, John L.,
209 S. Orange Ave.....Orlando
Ricker, Samuel F.,
33 E. Livingston Ave.....Orlando
Shoemaker, Samuel A.,
30 E. Church St.....Orlando
Spiers, Wm. Henry,
P. O. Box 1712 .....Orlando
Sutter, Leroy M.,
140 N. Orange Ave. .....Orlando
Taylor, B. E.,
Florida Sanitarium.....Orlando
Weed, Walter A.,
2nd Floor, Exch. Bldg.....Orlando
White, Roland T.,
211 S. Rosalind Ave.....Orlando
Wood, Robert G.....St. Cloud

PALM BEACH COUNTY MEDICAL SOCIETY (DISTRICT "F")

George, Wm. W., President,
1116 Harvey Bldg..W. Palm Beach
Rozier, Lauchlin McK., Vice-President,
411-14 Comeau Bldg.,
W. Palm Beach
Netto, Lloyd J., Secretary,
415 Comeau Bldg., W. Palm Beach
Herpel, Frederick K., Treasurer,
P. O. Box 1057.....W. Palm Beach
Arnold, Wilbur O.,
P. O. Box 1735.....W. Palm Beach
Baldwin, R. Henry,
1101 Harvey Bldg...W. Palm Beach
Binkley, John F.,
1206 Harvey Bldg...W. Palm Beach
Blair, William M.,
424 Comeau Bldg...W. Palm Beach
Boynton, Charles E., Jr.,
305 Harvey Bldg....W. Palm Beach
Brantley, Grady H.,
P. O. Box 336.....Lake Worth

* Deceased. † Honorary Member. § Life Member.

Buck, William J.....Belle Glade
Cason, John R.....Delray Beach
Clay, B. S.,
158 Sea Spray Ave. ...Palm Beach
Cooley, Roy Oscar,
P. O. Box 1735.....W. Palm Beach
Cram, George E.,
223 Sunset Ave. .....Palm Beach
Creel, Charles E.....Pahokee
Davis, Kenneth McC.,
Central Arcade .....Delray Beach
Dawson, George M.,
P. O. Box 1836.....W. Palm Beach
Denison, Raymond C.,
521 Lake Ave.....Lake Worth
Elarbee, George W. .....Pahokee
Fleming, S. Ward,
417 Harvey Bldg...W. Palm Beach
Gardner, William H.,
Comeau Bldg.....W. Palm Beach
Gill, Richard S.,
709 S. Olive Ave....W. Palm Beach
Hazen, Olen B.....Pahokee
Heath, Guy W.,
409-11 Harvey Bldg.,
W. Palm Beach
Henry, Gordon F.,
305 Citizens Bldg....W. Palm Beach
Jackson, Noah,
312 Hibiscus St.....W. Palm Beach
Johnson, Vesey M.,
Good Samaritan Hospital,
W. Palm Beach
King, Graham W., Jr.,
Love Bldg. .....Delray Beach
Lewis, Gaylord,
P. O. Box 2016.....W. Palm Beach
Miller, Alice R.,
418 Fern St.....W. Palm Beach
Newnham, J. A.,
511 Harvey Bldg....W. Palm Beach
Nowling, James C.,
309 Harvey Bldg....W. Palm Beach
Papot, Grace E.,
811 Harvey Bldg....W. Palm Beach
Pittman, J. H.,
P. O. Box 552.....W. Palm Beach
Powell, J. A.,
627 So. Olive.....W. Palm Beach
Randall, Floyd H.,
The Greenbrier,
White Sulphur Spgs., W. Va.
Rowe, Alva L.....Lake Worth
Sayad, William Y.,
1215 Harvey Bldg..W. Palm Beach
Schiffli, O. F. .....Clewiston
Shackelford, C. W.....W. Palm Beach
Shackelford, W. L.,
Good Samaritan Hosp.,
W. Palm Beach
Sory, B. B., Jr.,
Harvey Bldg. .....W. Palm Beach
Sory, James R.....Lake Worth
Stone, Vale D.,
Harvey Bldg. .....W. Palm Beach
Van Landingham, William E.,
P. O. Box 758.....W. Palm Beach
Warren, Hobart E.,
Phipps Plaza.....Palm Beach
Webb, Roy,
P. O. Box 454.....Palm Beach
Weems, Nat. M.....Boynton
Whitman, Frank S.,
512 Comeau Bldg....W. Palm Beach
Wilber, A. B.,
Lotus Club .....New York, N. Y.
Williams, William C., Jr.,
402 Comeau Bldg...W. Palm Beach
Young, Wilburn C.,.....Canal Point

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY (DISTRICT "B")

Coogler, A. C., President....Brooksville
Bradshaw, J. T.,
1st Vice-President.....San Antonio
Hudson, P. J.,
2nd Vice-President ..Crystal River
Bourke, John J.,
Secy.-Treas. .....Dade City
Cannon, Augustus B.....Lacoochee
Creekmore, George R.,
112 N. Main St.....Brooksville
Dame, George A.,
241 Main St.....Inverness
Dame, Leland H.....Inverness
Harvard, S. C. .....Brooksville
Jones, W. Wardlaw.....Dade City
Mills, David A.....Zephyrhills
Moon, William B.....Crystal River
Sistrunk, Robert D.....Dade City

PINELLAS COUNTY MEDICAL SOCIETY (DISTRICT "D")

Harden, W. W., President,
814 1st Natl. Bank Bldg.,
St. Petersburg
Anderson, Wm. D.,
1st Vice-Pres.....Tarpon Springs
Hardenbergh, John A., 2nd Vice-Pres.,
404 Power & Light Bldg.,
St. Petersburg
Feaster, O. O., Secretary,
St. Anthony's Hosp., St. Petersburg
McConnell, Whitman C., Treas.,
1005 Equitable Bldg., St. Petersburg
†Albaugh, Andrew P....Tarpon Springs
Anderson, Arnold S.,
712 Power & Light Bldg.,
St. Petersburg
Anderson, C. O.,
333 Third St. N.....St. Petersburg
Anderson, J. M.,
333 Third St. N.....St. Petersburg
Bieker, Annette M.,
825 Power & Light Bldg.,
St. Petersburg
Black, M. Eldridge,
311 Coachman Bldg.....Clearwater
Bradford, W. H.,
U. S. Veterans Hospital..Bay Pines
Burnette, P. C.....Tarpon Springs
Center, R. H.,
Coachman Bldg.....Clearwater
Cooper, J. H.,
First Natl. Bk. Bldg., St. Petersburg
Davis, W. M.,
342 First Ave. N.....St. Petersburg
Dawson, S. A.,
870 Seventh Ave. N., St. Petersburg
Dickerson, Lucien B.,
Williamson Bldg.....Clearwater
Dicks, Reid E.,
P. O. Box 104, 22nd St. Sta.,
St. Petersburg
Echard, T. B.,
203 Equitable Bldg., St. Petersburg
Farber, C. K.,
2635 Central Ave....St. Petersburg
Farber, William P.,
807 Power & Light Bldg.,
St. Petersburg
Funk, Neil E.,
702 Power & Light Bldg.,
St. Petersburg
Gable, Linwood M.,
Power & Light Bldg., St. Petersburg
Gable, Nonie W.,
Health Department,
175 Fifth St. N.....St. Petersburg
Gable, Nonie W., Jr.,
706 Power & Light Bldg.,
St. Petersburg
Green, Thadeus H.,
614 Hall Bldg.....St. Petersburg
Griffin, Thos. R.,
Power & Light Bldg., St. Petersburg
Groves, W. H.....Clearwater
Guinand, P. H.,
Jackson Bldg. .....Clearwater
Hebard, C. E.,
Fla. Natl. Bk. Bldg., St. Petersburg
Heibner, Eugene A.,
Power & Light Bldg., St. Petersburg
Herring, John A.,
350 Third Ave. N....St. Petersburg
Horne, Lester W.,
Power & Light Bldg., St. Petersburg
Jennings, Frank S.,
248 Third St. N.....St. Petersburg
Kauffman, Frank E.,
Coachman Bldg.....Clearwater
Knowlton, R. H.,
Power & Light Bldg., St. Petersburg
Lambdin, L.,
P. O. Box 1805.....St. Petersburg
Langley, Francis H.,
614 Times Bldg.....St. Petersburg
LeBreton, Prescott,
American Legion Hospital,
St. Petersburg
Leith, Richard B.,
201 Snell Bldg.....St. Petersburg
Lochner, G. M.,
406 Power & Light Bldg.,
St. Petersburg
Lustig, Emil,
500 Seventh Ave. N., St. Petersburg
MacCordy, Earl C.,
307 Equitable Bldg., St. Petersburg
Marr, Norval M.,
812 Power & Light Bldg.,
St. Petersburg
Mease, John A., Jr.,
Virginia Avenue.....Dunedin
Melville, Edmond J.,
335 Third Ave. N.....St. Petersburg
Miller, George E.,
411 Third Ave. N.....St. Petersburg
Mills, Alvin L.,
308 Fla. Natl. Bk. Bldg.,
St. Petersburg
Moeller, Maximilian W.,
1077 Fifteenth Ave. N.,
St. Petersburg
Murphy, Ralph D.,
P. O. Box 82.....St. Petersburg
Nelson, Orville N.,
U. S. Veterans Hosp.....Bay Pines
Nettles, Robbins,
402-5 Coachman Bldg...Clearwater
Nickle, Millen A.,
503-5 Coachman Bldg...Clearwater
O'Brien, Raymond K.,
E. 105 Fifth Ave. N., St. Petersburg
Owen, W. S.,
518 Power & Light Bldg.,
St. Petersburg
†Osgood, G. E.,
2804 Fourth St. S....St. Petersburg
†Peabody, J. D.,
456 Third St. N.....St. Petersburg
Post, Wm. Glenn, Jr.,
814-15 Power & Light Bldg.,
St. Petersburg
Prather, B. T.,
701 Fla. Natl. Bk. Bldg.,
St. Petersburg
Quicksall, J. Braden,
221 Taylor Arcade...St. Petersburg
Quicksall, William E.,
222 Taylor Arcade...St. Petersburg
Roope, A. P. .....Columbus, Ind.
Roush, Franklin W.,
4689 Lakeview Ave., St. Petersburg
Rudolph, Councill C.,
512 Power & Light Bldg.,
St. Petersburg
Simcox, Lawrence,
201 Third St. N.....St. Petersburg
Solomon, H. D.,
Power & Light Bldg. St. Petersburg
Stevens, Ralph E.,
827 Jungle Ave.....St. Petersburg
Strickland, Jesse A.,
712 Power & Light Bldg.,
St. Petersburg
Stuart, M. H.,
208 Equitable Bldg., St. Petersburg
Timberlake, Gideon,
6th Floor Times Bldg.,
St. Petersburg
Wade, Hugh W.,
512 Power & Light Bldg.,
St. Petersburg
Wells, John S., Jr.,
310 Coachman Bldg.....Clearwater
White, Benj. L.,
202 First Natl. Bk. Bldg.,
St. Petersburg
Whitford, Grace R.....Ozona
Williams, Carl A.,
P. O. Box 975.....St. Petersburg
Winchester, Harold E.,
P. O. Box 448.....Dunedin
Wood, Alvin J.,
208 Equitable Bldg., St. Petersburg
Wright, Claude B.,
Equitable Bldg.....St. Petersburg
Wylie, Leroy A.,
210-13 Medical Arts Bldg.,
St. Petersburg

POLK COUNTY MEDICAL SOCIETY (DISTRICT "D")

Hughes, Robert Lee, President,
225 E. Main St.....Bartow
Freeman, Grover C., Vice-President,
P. O. Box 1202.....Lakeland
Boulware, James R., Sec.-Treasurer,
P. O. Box 367.....Lakeland
Alexander, Omer R.,
Postal Arcade .....Winter Haven
Besenbruch, Peter W.,
Orange St.....Davenport
Bird, D. Paul,
P. O. Box 414.....Lakeland
Bond, Benj. J.,
612-13 Taylor Bldg..Winter Haven
Bosworth, Joe Marvin, Jr.,
1003 Marble Arcade.....Lakeland
Carefoot, G. H.....Ft. Meade
Clark, Samuel A.,
802 Marble Arcade Bldg., Lakeland

* Deceased. † Honorary Member. § Life Member.

Cline, R. L.,
P. O. Box 462.....Lakeland
Cordes, Henry B., Jr.,
P. O. Box 84.....Frostproof
Early, C. S,
Spencer-Futch Bldg.....Lakeland
Fuller, Henry .....Mulberry
Gilbert, R. E.,
19 Postal Arcade.....Winter Haven
Gilchrist, J. G.,
P. O. Box 744.....Bartow
Griffin, J. D.,
203 Hartzell .....Lakeland
Hargrove, Julian L.,
Polk County Hospital.....Bartow
Harness, A. J.,
417 McDonald St. .....Lakeland
Harris, Esau A. .....Brewster
Horton, Waldo,
539 Ave. B., N. W....Winter Haven
Hurlburt. C. J.....Bartow
Irons, F. E. .....Winter Haven
Koon, Alpheus C.,
513 W. Lemon St. .....Lakeland
Lancaster, L. L.,
680 Broadway .....Bartow
Lester, John G.,
P. O. Box 548.....Lakeland
Lindsey, Sherrod A.....Ft. Meade
Lowry, James B.,
P. O. Box 66.....Nichols
McMurray, James W.,
P. O. Box 174.....Bartow
Martin, Emmett E.,
Wray Bldg. .....Haines City
Mooty, Ross H. .....Winter Haven
Murphy, C. H.....Bartow
Murphy, H. K.,
Polk & Main Sts.....Mulberry
Newman, Heber P. .....Bartow
Nicholson, L. B.,
307 Marble Arcade .....Lakeland
Overstreet, Geo. C.,
Marble Arcade.....Lakeland
Peacock, William F.,
Barnett-Embry Bldg.....Bartow
Pearce, C. C. .....Mulberry
Pennington, B. Y.....Lake Wales
Ragsdale, Velpeau H.,
A. A. C. Co. Hospital.....Pierce
Roberts, Tenney H.,
328 N. Florida Ave.....Lakeland
Shafer, W. W. .....Haines City
Sherman, William E.,
716 W. Central Ave...Winter Haven
Simmons, Thos. G.,
Corlett Bldg. .....Auburndale
Simpson, W. T.....Winter Haven
Smith, Samuel F.,
P. O. Box 628.....Lakeland
Stetson, A. G. C.,
Sullivan Bldg.....Lakeland
Sullivan, Raleigh R.,
1006 Marble Arcade Bldg., Lakeland
Tillis, W. L.,
502 Marble Arcade Bldg., Lakeland
Tinkler, B. R. .....Lake Wales
Tomlinson, J. P., Jr.....Lake Wales
Tomlinson, J. P., Sr.....Lake Wales
Vaughn, John W.,
P. O. Box 475.....Lakeland
Watson, Herman.
P. O. Box 944.....Lakeland
Wilhoyte, Roy E.....Lake Wales
Williams, E. L.....Ft. Meade
Wilson, John F., Jr.,
P. O. Box 254.....Lakeland

PUTNAM COUNTY MEDICAL SOCIETY (DISTRICT "C")

Drexel, A. E., President,
P. O. Box 667.....Palatka
*Warren, Edmund W., Secy.-Treas.,
P. O. Box 88.....Palatka
Ford, Edward W. .....Crescent City
Johnson, H. A. .....Palatka
Strong, S. B.,
Station Hospital, Ft. Oglethorpe, Ga.
Zeagler, G. M.,
Glendale Hospital .....Palatka

ST. JOHNS COUNTY MEDICAL SOCIETY (DISTRICT "C")

Britt, Reddin, President,
P. O. Box 1226.....St. Augustine
Grace, Charles C., Vice-President,
East Coast Hospital..St. Augustine
Bennett, John L.,
Secretary .....St. Augustine
Potter, George W., Treasurer,
East Coast Hospital..St. Augustine
Estes, Edgar S.,
305 First Natl. Bk. Bldg.,
St. Augustine
Harris, R. D. .....St. Augustine
King, Raymond,
Strong Mem. Hospital,
Rochester, N. Y.
Lockwood, Vernon A.,
East Coast Hospital, St. Augustine
Spencer, J. J.....St. Augustine
Walkup, A. Clark,
116 St. George St.....St. Augustine
White, Herbert E.,
401-5 First Natl. Bk. Bldg.,
St. Augustine

ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY (DISTRICT "E")

Parker, J. D., President,
P. O. Box 942.....Stuart
Council, Melton D., Vice-President,
Arcade Bldg.....Ft. Pierce
Hardee, E. B., Sec.-Treas....Vero Beach
Boothe, R. C. .....Ft. Pierce
Burns, Van William.....Stuart
Clark, H. D.,
Ft. Pierce B. & T. Bldg...Ft. Pierce
Claxton, W. A.,
Veterans Hospital ....Oteen, N. C.
Davis, Claude L.....Okeechobee
Hardie, Grover C.,
207½ Orange Ave.....Ft. Pierce
Harrell, G. L. .....Vero Beach
*Pumpelly, Wm. C. .....Ft. Pierce
Whiddon, Lester Lee,
200-1 Peacock Bldg. .....Ft. Pierce

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Morton, Arthur O., Vice-Pres.,
Commercial Court.....Sarasota
Harris, J. E., Sec.-Treas.,
224 Commercial Court.....Sarasota
Burgner, Blanche A. .....Sarasota
Cribbins, Orville H.,
224 Commercial Court.....Sarasota
Halton, Joseph,
Pineapple Ave. .....Sarasota
Hoskins, W. H.....Venice
Johnston, W. J.,
215 Commercial Court.....Sarasota
Kennedy, Davis R.,
1st Bk. & Tr. Bldg.....Sarasota
Myers, Nicholas P. .....Ft. Meade
Patterson, John C.,
Palmer Nat'l Bk. Bldg.....Sarasota
Pinkham, Edw. W. .....Sarasota
Shelby, Edmund P. .....Venice
Taylor, T. W.,
Walpole Bldg., Main St...Sarasota

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Mitchell, Clifford M., Vice Pres., Sanford
Denton, John T., Sec.-Treas.,
Meisch Bldg. .....Sanford
Knox, A. W.,
Masonic Temple.....Sanford
Langley, W. T.,
Meisch Bldg. .....Sanford
Martin, John W.,
P. O. Box 95.....Oviedo
Moore, Thomas G. .....Osceola
Puleston, Samuel,
Brumley Puleston Bldg. ...Sanford
Selman, G. S.,
Lakeview Ave. .....Sanford
Smith, Henry D.,
Touchton Drug Co. Bldg....Sanford
Tolar, Julian N.,
First St. .....Sanford

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President .....Wildwood
Mitchell, W. E., Sec.-Treas.....Bushnell
Carter, Clyde L.....Wildwood
Seymour, David M.....Bushnell
Wood, Samuel C. .....Leesburg

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Baker, W. J., President.....Foley
O'Quinn, Charles A., Sec.-Treas., Perry
Bryan, W. H.....Scanlon
Ellis, John C. .....Perry
Greene, Ralph J. .....Perry
Warren, Geo. H.,
Main St. .....Perry
Weeks, J. L. .....Perry

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Henry, H. W., Vice Pres.,
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West, Hugh, Sec.-Treas.....DeLand
Bouchelle, Louis B. .....New Smyrna
Brown, L. V. L. .....DeLand
Chandler, J. R.,
110 S. Ridgewood Ave.,
Daytona Beach
Chowning, W. C.,
111 Palmetto St. .....New Smyrna
Clemmer, Charles A.,
P. O. Box 3236.....Daytona Beach
Davis, Joseph B.,
Halifax Dist. Hospital,
Daytona Beach
Dillard, T. H. .....DeLand
Doern, William .,
1743 N. Cambridge,
Milwaukee, Wisc.
Fogarty, Joseph N.,
424 Ocean Blvd.....Daytona Beach
Forster, Davis,
701 N. Orange Ave....New Smyrna
Glatzau, L. W.,
122 S. Palmetto Ave., Daytona Beach
Green, George M.,
102½ S. Beach St....Daytona Beach
Hahn, Theodore F.,
Dreka Bldg. .....DeLand
Howe, Raymond,
P. O. Box 1582.....Daytona Beach
Howe, Roy,
222 Volusia Ave.....Daytona Beach
Johnson, Harry D.,
P. O. Box 1242.....Daytona Beach
Mitchell, J. J. .....DeLand
Merryday, Harry L.....Daytona Beach
Miller, B. E.,
412 Canal St. .....New Smyrna
Miller, Harold E.,
102 Faulkner St.....New Smyrna
Miller, R. L.,
258½ S. Beach St...Daytona Beach
Myres, M. J.,
Room 3, 258½,
S. Beach St.....Daytona Beach
Pay, W. C.,
221 W. Rich Ave.....DeLand
Puleston, Fred,
Box L, Pen. Sta.....Daytona Beach
Rawlings, James Emery,
221 Orange Ave.....Daytona Beach
Rogers, M. Josie,
436 Rogers Court....Daytona Beach
Rutter, Joseph H.,
122 S. Palmetto Ave., Daytona Beach
Stern, Maximilian,
223 Ocean Blvd.....Daytona Beach
Taylor, Joseph E. .....DeLand
Tribble, C. E.,
Dreka Bldg. .....DeLand
Wells, J. Ralston,
Woolworth Bldg.....Daytona Beach
*White, J. Blake,
Osceola-Gramatan Hotel,
Daytona Beach
Williams, W. J. .....Seville
Wood, Evans B.,
P. O. Box 5295.....Daytona Beach

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Spires, Ralph B., Vice-Pres.,
DeFuniak Springs
Williams, A. G., Sec.-Treas...Lakewood
McDonald, C. W.....DeFuniak Springs
Spires, W. G. .....Darlington
Stephens, S. E.....Laurel Hill

* Deceased. † Honorary Member. § Life Member.

ANNOUNCEMENT REGARDING APPOINTMENT OF SENIOR MEDICAL INTERNES BY THE UNITED STATES PUBLIC HEALTH SERVICE

The United States Public Health Service will consider applications to fill a number of vacancies which exist at the present time and also vacancies which will occur about July first next, for second year medical internes. Any young physicians, not over thirty years of age, who have graduated from a class "A" medical college and who have completed, or will shortly complete, one year's interneship in an approved hospital are eligible to apply.

The Public Health Service desires to secure applications only from candidates who are interested in the Service as a career and who desire to request permission to appear before a board of commissioned officers for examination for appointment as Assistant Surgeons in the regular commissioned corps, on or about the time they will complete a year's service as internes in the Public Health Service.

Appointments effective on and after July 1, 1936, to vacancies at Marine Hospitals and the U. S. Narcotic Farm at Lexington, Kentucky, will carry a gross compensation of $1,800 per annum, from which a deduction of $690 per annum will be made if quarters, subsistence, and laundry are furnished. Appointments to vacancies at Federal Penal and Correctional Institutions will carry a gross compensation of $1,620 per annum, from which a deduction of approximately $240 per annum will be made by the Department of Justice if quarters, subsistence, and laundry are furnished. Internes are required to occupy Government quarters whenever same are available. Such quarters cannot be shared by any of the interne's dependents.

Those interested in making application should address an inquiry to the Surgeon General, U. S. Public Health Service, Washington, D. C., stating the date they will be available for duty and more complete information and the necessary blanks upon which to make application will be furnished.

STATE NEWS ITEMS

During the latter part of January, President Herbert L. Bryans completed another of his tours over the state. Doctor Bryans left Pensacola by train and arrived in Jacksonville Thursday, January 23. After visiting some of the officers and committee chairmen in Jacksonville, Doctor Bryans proceeded by automobile down State. He conferred with members and officers of the Association in the following cities: Orlando, Lakeland, Tampa, St. Petersburg, Bradenton, Sarasota, Ft. Myers, Miami, Ft. Lauderdale, West Palm Beach, Ft. Pierce, Melbourne, Daytona Beach and St. Augustine. Doctor Bryans was very fortunate in reaching Tampa in time for the Hillsboro County Medical Society's annual banquet, at which he was guest of Dr. William Rowlett.

* * *

Dr. H. Hamilton Cooke of Miami addressed the Lake County Medical Society at its January 2nd meeting on "Traumatic Injuries to the Brain and Treatment Thereof."

* * *

Dr. Sam J. Roberts of Miami announces the removal of his offices to 347-348 Ingraham Building.

* * *

Dr. W. D. Anderson, formerly of Largo, has moved to Tarpon Springs.

* * *

Dr. and Mrs. Francis H. Langley of St. Petersburg announce the birth of a daughter, Ann Carter Langley, June 1, 1935.

* * *

Dr. Irl E. Martin of Ocklawaha has moved to Miami and become associated with the Tumlin Clinic, 800 N. E. Second Avenue.

* * *

Dr. Shuler H. Etheredge and Miss Agnes L. Day of Tampa were married in Sebring, November 26, 1935.

* * *

Dr. Kenneth Phillips of Miami presented a paper on "The Fifth, Ninth and Tenth Nerves in Bronchial Asthma" before the American Laryngological, Rhinological and Otological Society, Southern Section at Jackson, Miss., January 18.

* * *

Dr. R. H. Farringer of Hollywood announces the removal of his offices to 1666 Hollywood Boulevard.

Dr. Francis H. Langley of St. Petersburg has recently been made a Fellow of the American College of Surgeons.

* * *

Dr. Read N. Calvert, formerly medical director and surgeon of the Florida Sanitarium and Hospital at Orlando is now on the surgical staff of the Washington Sanitarium and Hospital, Washington, D. C.

* * *

Dr. Raymond H. King, formerly of Jacksonville and Hastings, is taking two years of training and study in otorhinolaryngology at the Strong Memorial Hospital and University of Rochester School of Medicine and Dentistry, Rochester, N. Y.

* * *

Dr. F. L. Fort of Jacksonville was, during the month of January, named a member of the National Advisory Committee on Infantile Paralysis. This organization annually sponsors the Roosevelt birthday balls.

* * *

Dr. E. F. Carter of Tampa is the proud grandparent of Joan Henderson, born in the Municipal Hospital, Tampa, December 4, 1935.

* * *

Dr. H. F. Ermshar, formerly on the staff of the Florida Sanitarium and Hospital, Orlando, has joined the medical staff of the Washington Sanitarium and Hospital, Washington, D. C.

* * *

Dr. Robert B. McIver of Jacksonville was recently named president of the medical staff of the Duval County Hospital by the chiefs of the hospital's twelve departments. Dr. McIver succeeds Dr. Shaler Richardson, who has been president for the past two years. Other officers elected were Dr. Clayton E. Royce, vice-president, succeeding Dr. W. M. Shaw; and Dr. T. M. Palmer, secretary, succeeding Dr. Louie Limbaugh.

* * *

The Twentieth Annual Session of the American College of Physicians will be held in Detroit with headquarters at the Book-Cadillac Hotel, March 2-6, 1936. About fifty eminent authorities will present papers at the general scientific sessions, while clinics and demonstrations will be conducted at the Harper, Receiving, Ford, Grace, Herman Kiefer and Children's Hospitals of Detroit.

* * *

The many friends of Dr. Mary Freeman of Perrine will regret to learn of her death on February 2 in an automobile accident.

EDGAR S. ESTES

Dr. Edgar Estes was the son of the late James Wesley and Mary Brown Estes. He was born in Cumming, Georgia, November 30, 1879, coming to Florida in early childhood.

He was a graduate of Stetson University and the University of Virginia, completing his course of medicine in 1905.

He was a member of the Nu Sigma Nu and Phi Kappa Eta fraternities. He was an interne in the New York City Hospital for two years, and later connected with the Rockefeller Foundation, in the research field. Following this he was connected for some time with Dr. Tudor of Saranac Lake and later moved to Bisbee, Arizona, where, for a number of years, he was assistant chief surgeon at Copper Queen Mining Hospital.

He finally located in St. Augustine. He was chief surgeon of the Flagler Hospital for twenty years, resigning from these duties several months ago. He was a member of the Grace Methodist Church, a member of the Masonic Order and of the Order of Mystic Shrine. He was also a member of the American Medical Association, Southern Medical Association, Florida Medical Association, St. Johns County Medical Society, and a member of the American Legion, having served in the World War as the Captain of a Medical Corps.

He served for many years as health officer of the city.

The deceased is survived by his widow, Mrs. Julia Wall Estes, two children, Miss Mary Estes, and Lt. E. S. Estes, Jr., of New Orleans, La.; three sisters, Mrs. Fred Henderich, St. Augustine, Mrs. James Robinson, Grantwood, New Jersey, and Mrs. George Gleason, Eau Gallie, and one brother, George L. Estes, of Washington, D. C.

Dr. Estes died in St. Augustine December 6, 1935.

EARL H. McRAE

Dr. Earl H. McRae, prominent Tampa physician, died January 21, 1936, after a lingering illness.

Born in Chesterfield, South Carolina, in 1887, Dr. McRae came to Tampa in 1914 after receiving his doctor's degree at the Atlanta College of Physicians and Surgeons in 1911.

He was a member of the Army Medical Corps and served with distinction both in this country and overseas. He was chairman of the Tampa Red Cross Chapter, past president of the Hillsboro County Medical Society, member of the American Medical Association and the American College of Surgeons.

HERRMAN H. HARRIS

Dr. Herrman H. Harris, 53, prominent Jacksonville physician for 25 years, died January 20, 1936, in St. Vincent's Hospital, from a heart attack.

Dr. Harris had been critically ill since December 27, when he was admitted to the hospital but his death came as a shock to members of his family and intimate friends. He had been in failing health for nine years.

Born in Scotland, Georgia, December 23, 1883, Dr. Harris was the son of Sigmund and Fannie Bessie Harris. With the family, he later moved to Eastman, Georgia, where he attended the public schools. He graduated from the University of Georgia and Tulane Medical College, after which he came to Jacksonville to practice medicine.

Dr. Harris volunteered for war service in 1917 as a captain and spent 18 months overseas stationed at Verdun with the Thirteenth Engineers and the Fourth French Army. He participated in battles at St. Mihiel and the Argonne.

He served as chief evacuation officer for the Verdun sector during which time he was promoted to the rank of colonel in the Medical Corps. He was one of the three colonels in the Medical Corps from this State.

In 1911, Dr. Harris married Miss Pearly Levy, daughter of Mr. and Mrs. H. P. Levy of Hartford, Conn. Besides his widow, he leaves one daughter, Miss Hannah Bessie Harris, and three brothers, Harold Harris of New York City, Carol Harris, Los Angeles, Cal., and Edwin Harris of Durham, N. C.

Dr. Harris was a past president of the Duval County Medical Society and a member of the Board of Directors of the American Heart Association. He also was a member of the Florida, Southern and American Medical Associations.

The prominent Jacksonville physician served as Chief of Staff of St. Luke's Hospital for nine years. He also served at both St. Vincent's and the County Hospitals.

During the early years of the war he was active in the 40 and 8 Society, the American Legion, the Shrine and the Elks. He resided at 2537 St. Johns Ave.

Dr. Harris was a senior member of the medical firm of Harris, Kirk and Ferrara. He was a noted heart specialist and had hundreds of friends who will regret to learn of his death. His life was one of service.

HAYNES BRINSON

The recent passing of Dr. Haynes Brinson of Kissimmee caused profound sorrow throughout Osceola County where he was known and loved for all the good qualities that constitute a gentleman and physician. No one has ever been more generous to the general health and welfare of the poor people of this section, and his funeral service, held from Grissom's was largely attended by those whom he had befriended when ill and downhearted.

Dr. Brinson was born July 22, 1881, in Valdosta, Ga., but lived for many years in Cecil, where he practiced his profession, after graduating with signal honors from Emory University. He settled in Kissimmee in 1921 after his marriage to Miss Bid Thompson of Adel, Georgia. Two children were born of this union, one dying in infancy; the other, Edward, survives his father.

As an indication of the deep love and affection held for this fine man, hundreds attended the last services and old and young, white and black, unashamedly shed tears as they gazed for the last time on their friend and benefactor. Almost the entire membership of the Orange County Medical Society, of which the deceased was an honorary member, was in attendance and rendered homage to their departed brother. No death in Osceola County in recent years has

caused such universal sorrow as that of Dr. Haynes Brinson.

Dr. Brinson died at Kissimmee January 6, 1936.

A physician often advises his patients to have a hobby. Many physicians strengthen their advice by having hobbies of their own. Sculpturing is the hobby of Dr. J. Knox Simpson of Jacksonville, who has unusual talent. Recently Doctor Simpson's work was recognized publicly. A beautiful plaque, designed by Doctor Simpson, has been placed in the Riverside Presbyterian Church in Jacksonville, portraying the likeness of the late Joseph G. Venable, D.D., who was the first pastor of that church. This plaque was unveiled at the twenty-fifth anniversary of the founding of that church on Wednesday, February 5.

* * *

Members of the Association who have hobbies are urged to write to the Association Secretary in order that the hobbies of physicians may be recognized. It has been suggested that an exhibit booth at the annual convention be set apart for exhibiting the hobbies of our members. If you are interested, please write to the Secretary, Box 1018, Jacksonville.

* * *

Dr. and Mrs. Julius C. Davis of Quincy were at home to their friends on the evening of January 28, the occasion being the twenty-fifth anniversary of their marriage.

FOR SALE—Equipment of late Dr. W. C. Pumpelly: x-ray outfit complete, consisting of Acme-International Vertical Fluoroscope with tube; transformer; shields; also x-ray tube, tube stand and Victor timer. If complete outfit is purchased, will include film holders, developing tank, etc. Also for sale: Sanborn metabolism machine. All equipment in good condition. Write W. S. Pumpelly, P. O. Box 251, Ft. Pierce, Fla.

COMPONENT COUNTY SOCIETIES

BREVARD COUNTY MEDICAL SOCIETY

The Brevard County Medical Society has launched a new plan for society meetings. During 1936 the Society will be entertained each month at the home of some member. Dr. and Mrs. Thos. C. Kenaston entertained the Society at dinner at their new home in Rockledge, January 18. The dentists of Brevard County were among the guests. Dr. and Mrs. Kenaston treated their guests to a most delightful evening during which the Brevard County Medical Society elected officers for the current year, as follows:

President—I. F. Bean, Melbourne.
Vice-President—N. T. Counts, Cocoa.
Sec'y-Treasurer — Bob Schlernitzauer, Rockledge.
Delegate—W. C. Page, Cocoa.
Alternate—I. M. Hay, Melbourne.

Dr. I. M. Hay invited the society to meet at his home in February.

BROWARD COUNTY MEDICAL SOCIETY

At the December meeting of the Broward County Medical Society, election of officers was held, which resulted as follows:

President—E. M. Hendricks, Ft. Lauderdale.
Vice-President—R. H. Stovall, Ft. Lauderdale.
Sec'y-Treas.—Robert E. Blount Ft. Lauderdale.
Delegates—L. F. Robinson and B. F. Butler.
Alternates—H. J. Peavy and R. E. Blount.

DADE COUNTY MEDICAL SOCIETY

The December meeting of the Dade County Medical Society was held at the Rod and Reel Club. Following reports of the various committees, election of officers was held and the following were elected to serve for 1936:

President—John E. Hall, Miami.
Vice-President—Harrison A. Walker, Miami Beach.
Secretary—Major E. Threlkeld, Miami.
Treasurer—H. A. Barge, Miami.

DUVAL COUNTY MEDICAL SOCIETY

The Duval County Medical Society held its regular meeting at the Mayflower Hotel, Jacksonville, Tuesday evening, February 4. The scientific program consisted of a paper by Dr. Harry A. Peyton on "Cancer of the Small Intestine."

HILLSBORO COUNTY MEDICAL SOCIETY

At the annual meeting of the Hillsboro County Medical Society, election of officers resulted as follows:

President—William C. Blake, Tampa.
Vice-President—Robert C. Black, Plant City.
Sec'y-Treas.—James S. Grable, Tampa.

LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY

The quarterly meeting of the society comprising the second district of the Association was

held at the Woman's Club, Quincy, January 16 at 3:00 p. m. The following interesting scientific program was followed by a barbecue:

"Lantern Slide and Color Movie Demonstration of the Results Obtained in the Treatment of an Extensive Carcinoma," H. B. McEuen, Jacksonville.

"A Review of the Modern Treatment of Burns," William W. Massey, Quincy.

"Acute Coronary Thrombosis," C. D. Whitaker, Marianna.

"E. E. N. T.—Points of Interest to the General Practitioner," R. M. Clements, Chattahoochee.

MARION COUNTY MEDICAL SOCIETY

At the annual meeting of the Marion County Medical Society, the following were elected to office for 1936:

President—J. N. Moore, Ocala.

Vice-President—Carl S. Lytle, Dunnellon.

Sec'y-Treas.—R. C. Cumming, Ocala.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

The Pasco-Hernando-Citrus County Medical Society held its regular monthly meeting in Brooksville at the Tangerine Hotel, Thursday, January 9. Dr. George R. Creekmore was host. After a delicious dinner had been served, Doctor Creekmore presented a paper on "Thigh Amputations," which was well discussed by the doctors present. Those in attendance were: George A. Dame, Inverness; W. H. Cox, A. C. Coogler, George R. Creekmore, S. C. Harvard, Brooksville; W. W. Jones, J. T. Bradshaw and John J. Bourke, Dade City.

THE ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY STANDS 100% PAID FOR 1935. DURING THAT YEAR THE SOCIETY WAS MANNED BY J. D. PARKER, PRESIDENT; M. D. COUNCIL, VICE-PRESIDENT, AND E. B. HARDEE, SECRETARY-TREASURER.

THE SARASOTA COUNTY MEDICAL SOCIETY BECAME THE TWENTIETH SOCIETY TO REPORT 100% DUES PAID FOR 1935. THIS MAKES PRACTICALLY TWO-THIRDS OF THE COMPONENT SOCIETIES ON THE "HONOR ROLL."

WOMAN'S AUXILIARY

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State Editor
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1356 Willowbranch Ave.,
Jacksonville, Florida

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DUVAL COUNTY AUXILIARY

The January meeting of the Woman's Auxiliary to the Duval County Medical Society was held in the "Party House" with Mrs. O. P. Broadbent, president, presiding. Mrs. J. W. Hayes, secretary, read the opening prayer. Interesting reports were heard from all standing committees.

Mrs. Broadbent read the charges sent out by the State president, Mrs. E. W. Veal, and approved by the State Medical Advisory Board, for use in the county auxiliaries throughout the State during the coming year, and urged the cooperation of the group in carrying out these charges.

Mrs. Broadbent announced the three-day meeting of the Florida Medical Association which will hold all of its business sessions at sea aboard the S.S. Florida of the Peninsular and Occidental Steamship Company, April 27, 28 and 29, while en route from Miami to Havana, Cuba. She expressed the hope that every member present would make a special effort to attend.

A report of the Southern Medical Auxiliary meeting held in St. Louis, Mo., in November was given by Mrs. E. W. Veal. Mrs. Broadbent stated that Mrs. Veal had been elected treasurer of the Southern Medical Auxiliary, an honor which reflects credit not only to the Duval County Medical Auxiliary but to the State of Florida. The Auxiliary regrets that one of its valuable members, Mrs. R. R. Killinger, is critically ill at this time.

Mrs. J. H. Owens, program chairman, introduced the guest speaker, Dr. T. Z. Cason, who

gave a most interesting talk on "Healthy Hearts."

Dr. Cason delighted his listeners with the splendid way in which he presented his subject, making it both interesting and educational and one long to be remembered.

The meeting was adjourned and the women invited into the dining room where dainty refreshments in yellow and green were served from a beautifully decorated table overlaid with a handsome lace cover and centered with a crystal bowl of yellow chrysanthemums and green fern and balanced with crystal candelabras and yellow lighted candles on either end. Mrs. E. W. Veal and Mrs. Horace R. Drew poured tea and coffee.

Hostesses were Mrs. Gordon Ira, Mrs. W. G. Harris, Mrs. George Richardson, Mrs. Neil Alford, Mrs. J. W. Hayes and Mrs. O. P. Broadbent. About twenty-five members were present.

Marion County Medical Auxiliary Entertains Jacksonville Group

Marion County Medical Auxiliary recently entertained at a lovely buffet luncheon in the home of Dr. and Mrs. E. G. Lindner on East Fifth Street, in Ocala, honoring Dr. Gordon H. Ira, chairman of the advisory committee of the Florida Medical Association, and Mrs. Gordon H. Ira, program chairman of the State Medical Auxiliary, Mrs. E. W. Veal, president of the State Medical Auxiliary and Mrs. S. M. Copeland, chairman of State press and publicity.

The Jacksonville party soon after arriving in Ocala were accompanied by Mrs. R. D. Ferguson, president of the Marion County Medical Auxiliary, to Camp Roosevelt and several other camps where the canal project is under construction affording each one the opportunity of seeing the largest and most expensive project ever undertaken in the State of Florida.

After returning to the home of Dr. and Mrs. Lindner they were met by all the local doctors of Ocala and their wives. The spacious rooms of this lovely home were thrown open and a cordial welcome from Dr. and Mrs. Lindner greeted the 24 guests assembled for luncheon.

Tables covered with beautiful embroidered linens and centered with clusters of kumquats set in tiny crystal bowls were arranged informally throughout the living room where the guests were seated after serving themselves buffet style to a most delicious repast which had been arranged on the dining room table, overlaid with an embroidered cover and centered with a large

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bowl of yellow and white chrysanthemums and fern, and balanced with two candelabras holding tall yellow lighted tapers on either end.

Following the luncheon, Mrs. Ferguson introduced Dr. Ira and asked him to speak to the group on anything pertaining to the work of the Auxiliary.

Dr. Ira talked on "Good Literature", and said in part:

"I need not illustrate or emphasize to you further the value of good literature. But we must direct our attention this afternoon to a little different direction other than toward Shakespeare and others that one would momentarily think of at the mention of such a subject.

"I propose for a few moments to introduce to you, rather intimately some literature that will be of vital interest to you; literature that will be absorbing and interesting; literature that is furnished by an organization that is excelled by none; namely, 'The American Medical Association.' It is literature that you can be proud to make a part of yourself, by reading and absorbing it; literature that you can recommend to lay organizations with the assurance that they will thank you later for the good turn."

He concluded by stating "The knowledge of the world necessary for our grandparents was not sufficient education for the sons and daughters of today. He asked: "Have you not wondered where you could secure really good literature for boys and girls of high school age, or the Story of Life for boys and girls of 10 years of age?"

He presented some 25 different books and articles, reading interesting quotations from some and reviewing others, creating a desire within his audience to know more about each book. A round table discussion followed Dr. Ira's talk which proved very helpful and educational.

A general vote of thanks was extended to Dr. and Mrs. Lindner and the hostess Auxiliary for their lovely hospitality in making the occasion one of great pleasure and enjoyment to all who attended.

Marion County Auxiliary

Mrs. J. N. Moore was hostess at the January meeting of the Marion County Medical Auxiliary. The meeting took the form of a delightful luncheon at the Candle-Glo tea room on Ocklawaha Avenue.

An attractive table was laid for thirteen in



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MANY physicians agree that there are certain situations in which the muscles and connective tissues are unable to do their work, as for instance—in some cases of pregnancy, visceroptosis, hernia, sacroiliac disturbances, postoperative conditions and the like. When either abdominal or back support is deemed by the physician requisite to a return to physiologic balance . . . and a fabric garment is prescribed for this purpose . . . the great difficulty—it will be admitted—is to secure supports that are scientifically constructed, reasonably priced and properly fitted to the individual. It has been the definite objective of S. H. Camp and Company for over a quarter of century to manufacture supports with these qualifications.

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To insure the proper fitting of supports, to acquaint the profession with Camp models and to keep both physicians and fitters apprised of new garments, it has been necessary to establish the Camp Professional Support Service. With the development of this Service and the excellence of Camp Supports has been won the approval of such organizations as the American Medical Association and the American College of Surgeons.

In the announcements which are to be featured this year, we propose to explain in detail the various phases of the Camp Professional Support Service . . . how each factor in the Service helps to solve this matter of supports—to provide garments scientifically constructed, reasonably priced and properly fitted to the individual.

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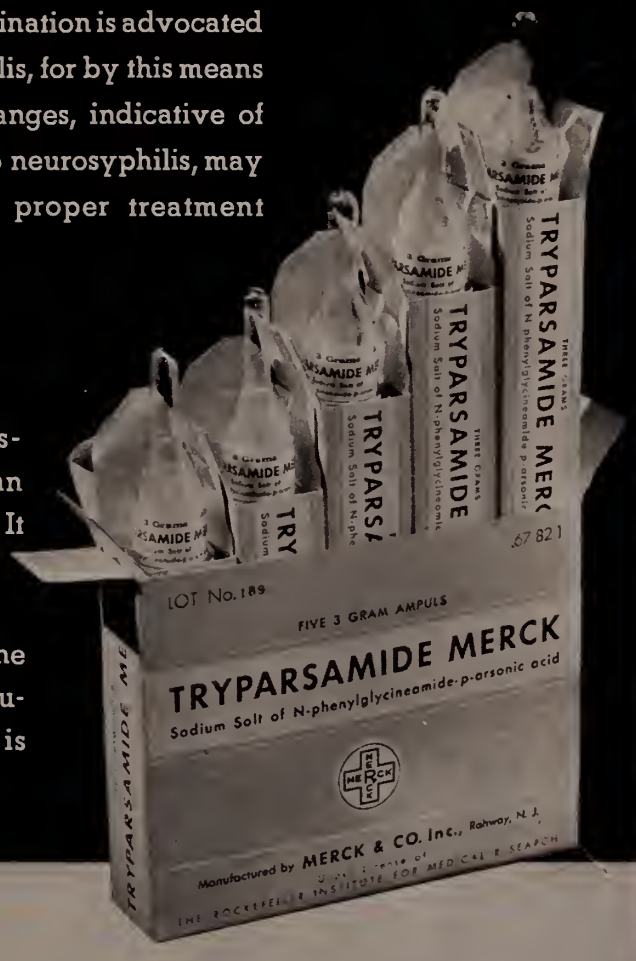
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one of the dining rooms of the popular tea room. A spring-like motif of yellow and green was carried out in the table appointments. Yellow bowls of fragrant narcissus and vari-colored sweet peas were flanked by lighted yellow tapers.

Following the luncheon a business meeting was called by the president, Mrs. R. D. Ferguson, at which time interesting reports were heard from all standing committees. A discussion followed in regard to Dr. Gordon Ira's talk on "Good Literature" a few days previously at the home of Dr. E. G. Lindner, and which every Medical Auxiliary should have at its command. Dr. H. C. Dozier suggested that the Auxiliary acquire several sets of such books and place them at the disposal of the high school library, the public library or some of the clubs in the city. The donating of such books would come under the Auxiliary's function as dealing with health education, public relations, philanthropic and social activities.

Members of the Auxiliary were invited to attend a Parent-Teachers' association meeting at Reddick School at which time two Ocala physicians were to speak on cancer and hookworm control.

Mrs. E. L. Scott and Mrs. F. J. Kirk were special guests at the meeting.

MEDICAL PROGRAM AT REDDICK HIGH SCHOOL

The program sponsored by the Marion Medical Auxiliary for the Reddick high school Parent-Teachers' Association was well received by a large and responsive audience. It was held at Reddick high school auditorium and intense interest was manifested by the number of questions asked at the close of the address.

Dr. J. M. Moore spoke on "Cancer Control," and used slides and a projectoscope to illustrate his lecture, thus making the subject thoroughly understandable to the lay mind. The films were loaned for the occasion by the American Medical Association.

Dr. R. D. Ferguson's address was on "Malaria and Hookworm," and was illustrated by blackboard sketches. It carried many helpful suggestions for both teachers and parents.

The auxiliary was much gratified to hear the school principal, Dow G. Beck, in a talk following that of the physicians, say that these two diseases, once so prevalent in Florida, were on the decrease since the distribution of health literature, and that Hygeia, a lay publication of the A. M. A., which has been presented to all the

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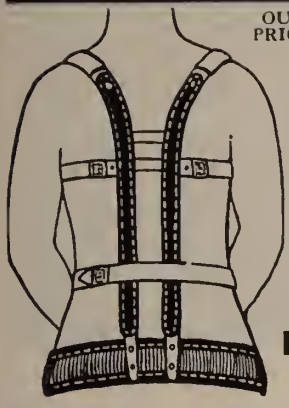
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high schools in Marion county, was the most generally read of all magazines in the library.

Two piano numbers by Reddick students closed the program, and a social period was enjoyed while cake and coffee were served.

Mrs. R. D. Ferguson, president of the medical auxiliary, who accompanied the physicians for the program, announced that there is now available literature on sex education suitable for children from six years old through high school age, which she will be glad to secure for those who are interested.

ADVERTISERS' NOTES

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Carbarsone has received widespread recognition as a valuable remedy in the treatment of amebiasis. Co-existing infections with other protozoa also appear to respond favorably to this arsenical.

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Summary of January Issue, The Borden Digest

The average diet can generally be improved by additions of the vitamin B-complex, vitamin D, and copper and iron, according to the investigation reported in Abstract No. 1.

Irradiated evaporated milk provides adequate vitamin D to protect the average infant against rickets, as shown in Abstract No. 5, while the study outlined in Abstract No. 6 demonstrates that evaporated milk is a particularly favorable



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Dental caries can be decreased by means of a diet rich in milk and other protective foods and in vitamin D, as pointed out in Abstract No. 4.

Successful treatment of hematemesis and melena with liberal puréed diets, in contrast to the usual starvation treatment, is outlined in the article which is the basis of Abstract No. 2.

Milk nullifies the effect of tannin in tea, according to the editorial mentioned in Abstract No. 3.

Experiments in vivo and in vitro on the rate of digestion of various forms of milk, fluid, evaporated, dried, lactic acid, etc., with and without added rennin, are reported in the papers summarized in Abstracts Nos. 7 and 8.

Permissive pasteurization of certified milk receives further acclaim in the editorial alluded to in Abstract No. 9.

New books on infant nutrition and pediatric treatment are reviewed in Abstracts Nos. 10 and 11, respectively; while three new books on preventive medicine and public health are collectively reviewed in Abstract No. 12.

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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	J. E. Maines, Jr., M.D., 331½ W. University Ave., Gainesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Tuesday 12:00 noon	White House, Gainesville		
Bay	W. C. Roberts, M.D., Panama City	Allen H. Miller, M.D., Millville			1	10%
Brevard	I. F. Bean, M.D., Melbourne	Bob Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies	3	33%
Broward	Elliott M. Hendricks, M.D., 314 Sweet Building, Fort Lauderdale	R. E. Blount, M.D., 360 S. E. 26th Ave., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale		
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	7	70%
Dade	John E. Hall, M.D., Box 2722, Miami	M. E. Threlkeld, M.D., Congress Bldg., Miami	1st Friday 8:30 P.M.	Club Rooms Huntington Bldg., Miami	53	24%
DeSoto-Hardee-Highlands	C. H. Kirkpatrick, M.D., P.O. Box 454 Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies		
Duval	W. M. Shaw, M.D., St. James Bldg., Jacksonville	H. W. Forter, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	3	2%
Escambia	A. M. Ames, M.D. Blount Bldg. Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola		
Hillsboro	William C. Blake, M.D., 412 Citizens Bank Bldg. Tampa	James S. Grable, M.D., 822 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa		
Jackson	C. D. Whitaker, M.D., Dekle Bldg. Mariana	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna	7	54%
Lake	J. D. Coupland, M.D., Eustis	W. L. Ashton, M.D., Umatilla	1st Thursday 12:30 PM.	Eustis		
Lee	William H. Grace, M.D., 15 Earnhardt Bldg., Fort Myers	H. Quillian Jones, M.D. 18-20 Leon Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers	4	36%
Leon-Gadsden-Liberty-Wakulla-Jefferson	R. F. Godard, M.D., Key Building, Quincy	B. A. Wilkinson, M.D., Telephone Bldg., Tallahassee	Quarterly 3:00 P.M.	Varies	10	26%
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison				
Manatee	H. Gates, M.D., P. O. Box 245 Bradenton	W. D. Sugg, M.D., Bradenton Bank Bldg., Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Club Bradenton		
Marion	J. N. Moore, M.D., 210-12 Professional Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala	15	71%
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies		
Orange	William E. Sinclair Clinic Bldg. Orlando	J. A. Pines, M.D., 106-10 E. Central Ave., Orlando	3rd Wednesday 8:30 P.M.	Varies		
Palm Beach	W. W. George, M.D., 1116 Harvey Bldg., West Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach	21	39%
Pasco-Hernando-Citrus	R. D. Sistrunk, M.D., Dade City	John J. Bourke, M.D., Dade City	2nd Thursday 7:00 P.M.	Varies		
Pinellas	F. E. Kauffman, M.D., Coachman Bldg., Clearwater	W. C. McConnell, M. D. 1005 Equitable Bldg. St. Petersburg	1st Friday 8:00 P.M.	Assembly Room, 5th Floor, P. & L. Bldg., St. Petersburg	25	33%
Polk	R. L. Hughes, M.D., 225 E. Main St., Bartow	J. R. Boulware, Jr., M.D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P.M.	Lakeland		
Putnam	Allen P. Gurganeous Palatka	A. E. Drexel, M.D., Palatka	2nd Thursday 7:00 P.M.	James Hotel, Palatka	7	88%
St. Johns	Herbert E White, M.D., 401 First Natl. Bank Bldg St. Augustine	R. D. Harris, M.D., St. Augustine	3rd Tuesday 8:30 P.M.	Varies		
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., P. O. Box 942, Stuart	E. B. Hardee, M.D., Vero Beach	3rd Thursday 8:00 P.M.	Varies		
Sarasota	C. B. Wilson, M.D., 1st B. & Tr. Bldg., Sarasota	J. E. Harris, M.D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P.M.	Varies		
Seminole	C. L. Park, M.D 515-6 1st Bank & Tr. Bldg. Sanford	J. T. Denton, M.D., Meisch Bldg. Sanford	2nd Monday 7:00 P.M.	City Hospital Sanford		
Sumter	A. B. Albritton, M.D., Wildwood	W. E. Mitchell, M.D., Box 237 Coleman	2nd Tuesday	Varies		
Taylor	W. J. Baker, M.D., Foley	C. A. O'Quinn, M.D., Perry	Last Friday 8:00 P.M.	Dixie-Taylor Hotel, Perry		
Volusia	G. A. Davis, M.D., Dreka Bldg., DeLand	Hugh West, M.D., DeLand	2nd Tuesday 7:30 P.M.	Varies		
Walton-Okaloosa	E. L. Huggins, M.D., Freeport	A. G. Williams, M.D., Lakewood	3rd Thursday 8:00 P.M.	Varies		

NOTE—Secretaries: Please submit information to complete the above schedule.



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SIXTY-THIRD ANNUAL MEETING, S. S. FLORIDA, APRIL 27, 28 AND 29, 1936

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— OF THE —
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Southern Medical Association, Baltimore, Md., November 17-20, 1936.

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CANNED FOODS AND THE PUBLIC HEALTH

II. Iron and Tin Salts

• The question is sometimes raised as to whether the metallic salts which canned foods may acquire from contact with tin containers are objectionable from the standpoint of public health. We are glad to present the facts in answer to this question.

The modern "sanitary style" can is manufactured from "tin plate". As the name implies, tin plate is made by plating or coating thin steel sheets with pure tin. This tin coating cannot be made absolutely continuous; under the microscope, minute areas can be noted in which the steel base is exposed.

Foods packed in plain or unenameled cans are, therefore, exposed to iron and tin surfaces. In enameled cans, foods are mainly in contact with inert lacquers baked onto the tin plate at high temperatures. However, because of minute abrasions in the enamel covering, unavoidably introduced during fabrication of the can, foods in enameled cans may also have limited contacts with iron and tin surfaces.

It is common knowledge that canned foods may acquire small amounts of these metals from contact with their containers. The acquisition of iron and tin salts in this manner is an electrochemical phenomenon (1); and the amounts of these metallic salts thus acquired will depend, among other factors, upon the character of the food. In general, the acid foods tend to take up more of these metals; especially when air is admitted after the can is opened. However, the quantities of tin or iron present in canned foods, as a result of reaction with the container, are small; the analytical chemist reports these amounts in "parts per million".

As far as iron is concerned, it is commonly accepted that the amounts of this element—recognized as essential in human nutrition—which may be present in canned foods, are innocuous.

As to the tin salts which may be present in canned foods, the Department of Agriculture has authorized the following statement as the result of its own investigation:

> "Our own experimental work, involving the ingestion of far larger amounts of tin than any previously reported, and supported by the experimental evidence of other investigators, leads us to the conclusion that tin, in the amounts ordinarily found in canned foods and in the quantity which would be ingested in the ordinary individual diet, is for all practical purposes, eliminated and is not productive of harmful effects to the consumer of canned foods." (2)

It may therefore be stated that the amounts of tin and iron salts normally present in commercially canned foods are without significance as far as possible hazard to consumer health is concerned.

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(1) Kohman and Sanborn, Ind. Eng. Chem. 20, 76, 1373 (1928); ibid, 22, 615 (1930).

(2) "Food-Borne Infections and Intoxications", F.W.Tanner, Twin City Pub. Co., Champaign, Ill. 1935, p. 90.

This is the tenth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

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The U. S. Pharmacopoeia (IX, 1916, and X, 1925) recognized cod liver oil as the oil from the livers of fishes of the family *Gadidae*. There being some 50 species in this family, in addition to the type species, *Gadus Morrhua*, our first studies were directed at the examination of the more important species classed as cod. It occurred to us that somewhere in nature there might exist a species, or a family, or an order of fish, the liver oil of which would make possible a mixture comparable with Oleum Morrhuae but higher in vitamin potency.

The study was then directed to other species. By 1927 we had quantitatively compared the antiricketic value of oils from 15 species of fish and 11 other oils and fats. This was the most extensive survey of vitamin D sources reported up to that time. Outstanding in this list was puffer fish liver oil with a vitamin potency 15 times that of cod liver oil. Puffer fish were not available in commercial amounts, but the fact that one species of fish yielded so high a vitamin store provided great stimulus to investigators.

We discovered that the potency of fish liver oils increases with the leanness of the livers. With this revelation, we began a survey of all available commercial fish, as well as of rarer species. Collectors were sent to distant continents and to the islands of the Pacific and Atlantic oceans. From ports which never before knew cold storage we arranged to obtain refrigerated livers for our experiments. This ichthyological survey was interrupted (1928) at the time we introduced activated ergosterol.

In 1929 the Norwegian investigator, Schmidt-Nielsen, reported halibut liver oil to be superior to cod in vitamin A. Upon investigating, we felt then, as we do now, that while halibut liver oil marked a distinct advance it left much to be desired since it was perforce an expensive source of vitamin D. Hence it came to be used chiefly to supply vitamin A as a vehicle for viosterol.

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Journal of the American Medical Association, Volume 104, page 980, March 23, 1935.

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REFERENCES:

Kugelmass, Clinical Nutrition in Infancy and Childhood, (Lippincott).

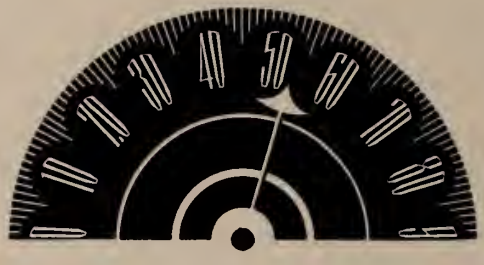
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McLean & Fales, Scientific Feeding in Infancy, (Lea & Febiger).

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IMMUNIZATION AGAINST CONTAGIOUS DISEASES OF CHILDHOOD*

WARREN QUILLIAN, M.D.,
Coral Gables.

It is the purpose of this paper to review some of the problems and methods of immunization as applied to the more common contagious diseases of childhood. Only recently has general recognition of the effectiveness of immunization methods in combatting these diseases been given.

An ideal method for artificial protection against disease should include a rapid production of permanent immunity, and a minimum number of treatments with reasonable safety. This ideal has not yet been reached. But recent investigations indicate progress, despite the variable problems of immunization presented in each of the diseases considered.

SCARLET FEVER

The Dick test consists of the intradermal administration of one skin test dose of scarlet fever toxin. It is used in an effort to select susceptible individuals and to determine later whether the injection of toxin has rendered them immune.[1][2] Negative Dick tests indicate immunity to the disease, but persistently positive tests may or may not indicate susceptibility. Toyoda[3] explains this by stating that the material used for testing consists of a thermolabile exotoxin and a thermostabile allergen. Many persons become sensitized to the latter product, thus interfering with the reliability of the test. Administration of the full doses of toxin in five injections causes the skin test to become negative in about 95% of susceptible individuals within two weeks after completion of the series. The Scarlet Fever Committee has recommended that five doses of 500, 2,000, 8,000, 25,000 and 80,000 skin test doses be administered at intervals of one week. Two weeks after the last dose is given, the Dick test is repeated, using one skin test dose on one arm and two skin test doses on the other. If either test is positive, a sixth injection of 100,000 skin test doses should be administered.[4] Evidence has been compiled indicating that immunity persists for at least a period of two years in 90 to 95 per cent of those receiving the standard dosage of toxin described above. Occasional severe local or general reactions to the injection of scarlet fever toxin have been observed.[5]

There is still some conflict of opinion concerning the toxin and the immunization method as employed at present. Fortunately, no opportunity has been afforded in Florida to study the problem on account of the widely scattered, infrequently encountered cases.

DIPHTHERIA

Enthusiasm of physicians and education of laymen have contributed to widespread active immunization against diphtheria. Toxoid seems to be replacing the use of toxin-antitoxin. This is due to the fact that the immunization efficiency of the former is higher; there are fewer reactions; no serum sensitization; and the product is more stable.[6] Since the pioneer work of Von Behring and Schick in 1913, there has been constant improvement of technique and methods of active control of the disease. At present a toxoid precipitated with aluminum potassium sulphate is in extensive use as a prophylactic measure. One dose of one cubic centimeter is injected subcutaneously. Its efficacy in stimulating antigenic reaction is due to its relative insolubility and consequent prolonged absorption.[6]

Graham, Murphree and Gill report that of 613 children, whose original immunity status was not known, 96.6% were Schick negative six months after a single injection. No individual may be considered immunized until a negative Schick test has been obtained. This is usually performed five or six months after immunization. Care should be observed that the test material is potent.

The percutaneous method of prophylaxis by inunction of an ointment containing both toxoid and unfiltered culture of dead diphtheria bacilli is not widely used in this country. Immunization is obtained in about 70% of the cases by this method.[8]

Straus[9] has accomplished slow absorption of

*Read before the Sixty-second Annual Meeting of the Florida Medical Association, Ocala, May 13-15, 1935.

a concentrated toxoid by using a single intramuscular injection in a lanolin base.

A study of my private case history records reveals an interesting comparison of the efficacy of toxin-antitoxin, toxoid (anatoxin-Ramon) and toxoid (alum-precipitated) in South Florida. The same method of Schick testing was used for all cases considered. Detailed results are tabulated below in Table "A".

In my experience the alum-precipitated toxoid has been productive of a higher percentage of Schick negative reactions. The clinical value of active diphtheria immunization is no longer questioned.

PERTUSSIS

Since 1928 Sauer has attempted control of pertussis with a vaccine prepared from recently isolated hemolytic strains of the Bordet-Gengou bacillus grown on Bordet medium prepared with human blood. Eight cubic centimeters of the vaccine, containing ten billion bacilli per cubic centimeter, is administered in three weekly doses. For immunity to develop, at least four months should intervene between the time of the last injection and exposure. The vaccine prepared according to Sauer specifications, is available commercially. It should be kept cold until used by the physician.(10)

The results obtained in a series of 1,380 children immunized, was reported by L. W. Sauer in the Southern Medical Journal, December, 1934. This brilliant and exhaustive study of both private and institutional cases indicates that it is now possible to establish an active immunity within four months which will persist for several years.

The injections are sometimes followed by a slight fever and temporary local reaction. No severe unfavorable general reactions have been reported.

TABLE 1. (SAUER)
AGE DISTRIBUTION OF IMMUNIZED CHILDREN.

8 to 12 months	258
12 to 24 months	388
2 to 3 years	150
3 to 4 years	80
Over 4 years (mostly of kindergarten age)	134
"Cradle" infants (age 1 mo.—(6 cc.)	370
Total	1,380

TABLE 2. (SAUER)
DISTRIBUTION OF IMMUNIZATION (1928-1934)

Private Patients	625
Health Department	235
Orphanage	150
"Cradle" infants (6 cc.)	370
Total	1,380

Although the total number of immunizations is quite equally divided between private and charity patients, the 300 crucial immunizations during the first five years were made on carefully selected private patients with vaccine prepared in Evanston; the remainder were given the approved commercial vaccine.

TABLE 3. (SAUER)
PROOF OF ACTIVE IMMUNITY
(Exposure 4 mos. to 6 years after injection)

Families with pertussis	28
Controls (brothers and sisters with pertussis)	45
Injected children exposed[1]	39
By one member	31
By two members	8
Casual exposures:	
Injected children exposed.[2]	145
Times exposed	278

[1]Sixteen of them had received the approved commercial vaccine.
[2]Eleven of them had received the approved commercial vaccine.

Result: No injected child contracted typical pertussis; in two, the disease occurred in aborted form.

As a supplement to this report it may be recorded that of 97 children immunized according to the above procedure during the past eleven months by me not one has developed pertussis, although intimate exposure to the disease is known to have occurred in four cases. In one of these, contact with a child who had pertussis took place within three months of the time of the last prophylactic injection. It therefore appears that active immunity is afforded to susceptible children by means of proper administration of vaccine prepared in accordance with the technique described by Sauer.

MEASLES

McKhann and Chu(12) first demonstrated that placental protein extracts contained substances, probably antibodies, which prevented measles in exposed susceptible patients. Of 95 non-immune patients exposed to measles in the course

TABLE "A"

Total Number of Cases Studied 245

Method of Immunization		Schick after six months to one year. No Test	Positive	Negative
A. Toxin-antitoxin	86	2	12	72
B. Toxoid (Ramon)	112	10	6	96
C. Toxoid (Alum-precipitated)	47	17	0	30

of hospitalization for other causes, the extract was administered early in the period of incubation. Ninety-one of these did not develop the disease, while the remaining four had a very mild modified form of measles. Placental extract is now available on the market as human immune globulin. Its effectiveness as a prophylactic agent depends upon injection early during the incubation period and the potency of the material used.

Charles Herrman[13] has successfully produced an active immunity in a large group of infants by direct application of infectious material from the nasal discharge of measles patients to the nasal mucosa of the susceptible infant.

Relative passive immunity has been obtained by the intramuscular injection of blood serum of convalescent measles patients,[14][15] by the injection of whole blood, of reactivated serum[17] and of ordinary parental serum.[18]

During the measles epidemic (April to June, 1934) in the Greater Miami district an opportunity was afforded to study and compare the efficacy of various types of measles prophylaxis. The group under consideration included 44 children observed in private practice and 15 resident at the Junior League Children's Home.

Of the institutional group of 15 (Junior League Home), four developed mild cases of measles within a period of 2 to 3 weeks after the last known exposure; the remaining 11 escaped any evidence of the disease, although all of them were susceptible and had been definitely exposed. Adult, immune, Wassermann negative serum, in dosages of 7 to 10 cc. was administered intramuscularly to all these children, whose ages ranged from 17 months to 10 years. No further effort was made to isolate them from active and convalescent measles cases then existent in the Home. Two of 11 successfully immunized against measles developed pertussis, and 1 had mumps during the month following prophylactic injection. Tabulated results were as follows:

Three different modes of procedure were followed in attempting immunization of the group of 44 private patients studied:

A. Twenty-eight received intramuscular injections of whole blood, freshly drawn from the vein of one of the parents. The amount injected varied with the age of the child, being from 10 to 35 cc. No attempt at typing or matching the blood of donor and recipient was made. Of this group, 5 developed measles subsequently. (Table 2).

B. Eleven were given convalescent serum, dosages varying as above, from 5 to 8 cc. The serum used was prepared by Mr. O. K. Powell from blood of patients recently recovered from measles. The usual standard laboratory technique of preparation was followed. Only one of the children protected in this manner developed the disease. In this instance symptoms occurred after an incubation period of three weeks following the last known exposure. It will be noted that in this group each child receiving convalescent serum was immunized within four days of the actual exposure. (Table 3).

C. Five were given immune adult serum, in dosages ranging from 5 to 20 cc. One of these had an attenuated form of measles without complications at the end of 2½ weeks. It is interesting to note that among this small group the child who received the largest amount of immune serum (20 cc.) was the one who subsequently developed clinical symptoms of measles. (Table 4).

TABLE 1.

Patient	Age	Amount of Human Adult Immune Serum Administered	Date.	Remarks.
V. G.	7 Yrs.	10 cc.	5-15-34	
J. K.	6 "	10 cc.	"	
L. S.	5 "	10 cc.	"	
B. Y.	5 "	10 cc.	"	
W. P.	5 "	10 cc.	"	Asthmatic. No reaction.
B. S.	5 "	10 cc.	"	
H. S.	7 "	10 cc.	"	
J. G. A.	4 "	10 cc.	"	
J. J.	5 "	10 cc.	"	
L. C.	17 Mos.	10 cc.	"	
L. B.	10 Yrs.	8 cc.	5-18-35	
G. B.	8 "	8 cc.	"	
J. B.	8 "	8 cc.	"	Conjunctivitis.
D. G.	5 "	7 cc.	"	Infected teeth.
J. R. P.	2 "	8 cc.	"	

TABLE 2

IMMUNIZATION BY ADMINISTRATION OF PARENTAL WHOLE BLOOD.

Patient	Date	Amount Given	Approximate Period Since Exposure	Results	Remarks
M. A.	5-5-34	28 cc.	2 days	No	
A. A.	5-5-34	18 cc.	3 "	No	
B. B.	2-6-34	18 cc.	4 "	No	
M. B.	5-12-34	20 cc.	3 "	No	A brother not immunized developed measles 8 days later.
B. B.	4-10-34	30 cc.	4 "	No	
D. B.	6-4-34	30 cc.	2 "	No	
R. C.	2-23-34	38 cc.	5 "	No	
A. C.	4-5-34	25 cc.	2 "	No	
N. F.	4-27-34	33 cc.	2 "	No	
S. F.	4-26-34	35 cc.	2 "	Yes	Mild eruption 15th day following injection.
J. H.	5-12-34	35 cc.	7 "	No	
D. LaS.	5-10-34	35 cc	3 "	No	
J. McC.	4-24-34	32 cc.	3 "	No	
B. M.	5-17-34	32 cc.	2 "	No	
V. M.	5-17-34	32 cc.	6 "	No	
E. R.	6-3-34	30 cc.	6 "	Yes	Temp. 101(F). Eruption 17th day following injection.
B. B.	5-16-34	35 cc.	4 "	No	
A. C.	6-26-34	30 cc.	4 "	No	
V. M.	5-21-34	30 cc.	4 "	No	
C. O.	6-10-34	28 cc.	2 "	No	
E. P.	5-9-34	38 cc.	4 "	Yes	Mild—12th day following injection.
G. S.	6-4-34	25 cc.	2 "	No	
J. S.	6-4-34	26 cc.	2 "	No	
P. U.	5-2-34	10 cc.	4 "	No	
B. W.	4-11-34	30 cc.	2 (?)	Yes	Duration eruption 2 days. Temp. 100 (F). Appeared 8th day after injection.
B. Y.	4-23-34	32 cc.	5 days	No	
P. L.	5-10-34	30 cc.	3 "	No	
H. W.	4-11-34	33 cc.	2 (?)	Yes	Mild eruption appeared 9th day following injection.

TABLE 3.

IMMUNIZATION BY ADMINISTRATION OF CONVALESCENT BLOOD SERUM.

Patient	Date	Amount Given	Approximate Period Since Exposure	Results	Remarks.
R. C.	5-19-34	5 cc.	2 days	No	
E. M.	5-21-34	5 cc.	2 "	No	
J. M.	5-21-34	5 cc.	4 "	No	
D. M.	5-21-34	5 cc.	4 "	No	
E. M.	5-21-34	5 cc.	4 "	No	
R. M.	5-21-34	5 cc.	4 "	No	
R. R.	5-22-34	5 cc.	4 "	No	
D. S.	5-27-34	8 cc.	2 "	No	
W. S.	5-27-34	8 cc.	2 "	No	
P. W.	6-10-34	6 cc.	2 "	Yes	Mild symptoms appeared 19 days after injection.
F. D.	5-25-34	5 cc.	4 "	No	

TABLE 4.

IMMUNIZATION BY MEANS OF PARENTAL BLOOD SERUM (NOT REACTIVATED).

Patient	Date	Amount Given	Approximate Period Since Exposure	Results	Remarks.
T. O'D.	5-12-34	5 cc.	5 days	No	
S. O'D.	5-12-34	9 cc.	5 "	No	
A. O'D.	5-12-34	10 cc.	5 "	No	
M. O'D.	5-12-34	20 cc.	5 "	Yes	Eruption persisted 2 days. Appeared 10th day after injection.
L. B.	5-18-34	8 cc.	2 "	No	

CONCLUSIONS

1. The accuracy of the Dick test and the reliability of present methods used for scarlet fever immunization is questioned by many. Infrequency of the disease in Florida and the frequent unfavorable reactions have prevented our inclusion of this as a routine procedure.

2. Active diphtheria immunization is possible and results obtained justify its routine adoption in private practice. Alum precipitated toxoid has given a higher percentage of Schick negative reactions among the cases considered in this paper.

3. Immunization against pertussis is established in a high percentage of cases when the vaccine is prepared and administered according to Sauer's technique. No unfavorable systemic reactions have been reported despite the large doses given.

4. Prevention or attenuation of measles can be accomplished by passive immunization with human serum or whole blood, or human placental extract. More general usage of these simple methods of prophylaxis in institutions should materially reduce the incidence of this disease in times of epidemic.

Modern immunization methods against the common contagious diseases are practical. When these methods are properly applied, complications and unfavorable sequelae are less. Their more general adoption would inevitably lead to a lower morbidity and mortality rate for the diseases considered.

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DISCUSSION

Dr. W. W. McKibben, Miami:

One cannot help being impressed by this paper. Dr. Quillian's statements are timely; they represent the painstaking and careful research work of a busy pediatrician. I don't see how my fellow townsman gets the time to go into such detail, with all the work he has to do.

Whooping cough, which Dr. Quillian asked me to discuss, is a very serious disease among children. It has been estimated that there are about 10,000 children who die in the United States every year from whooping cough, that is, its complications and sequelae. Children under five years of age are the most susceptible to it, and under three there are as many deaths from whooping cough as from scarlet fever, measles and diphtheria combined.

The history of whooping cough to me has been interesting. In 1916 I first began to use vaccine, preventive and curative. In 1923 I read a paper before the Massachusetts Medical Society, Pediatric Section, on the treatment of whooping cough. One of the doctors who discussed my paper said that he was only partially convinced that vaccine was the right treatment, and he discussed the treatment of whooping cough by x-ray. In my conclusion I stated that we were not using whooping cough vaccine in large enough doses and that we were not using it fresh enough and soon enough. As time went on we were convinced that we could use it satisfactorily as a preventive treatment. In the last two years I have been immunizing babies as a routine measure at one of the monthly checkups. I usually immunize them when six months of age, or even earlier. The results have been exceedingly satisfactory. I have been able to contact one hundred and fifty cases, and I find that four cases were definitely exposed to whooping cough, even sleeping in bed with infected children; probably one-third were directly or indirectly exposed to it.

I have had no serious results from injections of whooping cough vaccine, possibly a little tem-

perature in the afternoon, or local irritation. I did get one abscess from an injection where the child had impetigo.

As far as the actual treatment of whooping cough is concerned, I have used the vaccine as a curative measure over a long period of years. From 1916 to 1923 my records show 4,000 children treated by me and friends, for pertussis. From 1900 to 1916 we lost a great many children from complications. After 1916 we began to use vaccine as a curative measure and the mortality disappeared. I continued to use it with the idea that it prevented complications; I still use it.

Other treatments of whooping cough have been unsatisfactory. There are probably fifty-seven varieties of drugs used. For a symposium I sent out about three hundred questionnaires to pediatricians in the United States. The favorite prescription seemed to be antipyrin and sodium bromide in some syrup. Some used ether and oil injected intramuscularly or by rectum, one dram of ether to one cc. of oil. Another treatment I have already mentioned is x-ray.

I have not had a great deal of experience with drugs. I am trying to avoid them. I do believe that we have a very important therapeutic factor down here in Florida—climate. I have seen only one death from whooping cough in the tropics, a little premature marantic baby, a case that Dr. Quillian and I had. Vomiting could not be checked and the baby was admitted to the isolation ward at Jackson Memorial Hospital with broncho-pneumonia and died.

I want to impress on you the fact that I thoroughly believe that our ocean beach—the child playing as long as possible in the warm dry sand in proper weather—are very valuable factors in the treatment of whooping cough. That does as much good as anything that I know of as a curative measure. I regret that we cannot bring every child in the United States with whooping cough to our Florida beaches to get the benefit of our sunshine and salt air in the winter time.

Dr. Warren Quillian, Coral Gables (concluding):

Regarding dosage of pertussis vaccine, it has been my custom to give the first dose in one injection, the total amount being 2 cc. The second dose is given in two injections one and one-half cc. each. This is frequently followed by local tenderness and redness in the arm, which is transitory in character, usually disappearing within thirty-six hours. The third dose is similar to the second. I generally select the upper arm, using the triceps or deltoid muscle as the site of injection.

I would like to sound one note of warning in closing. Let's not deliberately expose some susceptible child in the family to one of these communicable diseases unless measures have been taken for prophylaxis. Often it will be an unfortunate individual who will develop an unfavorable complication. One finds some families who seem to feel that when a child is exposed it is just as well to let them have the disease and get through with it.

I think we are justified in talking this matter over with the parents. Also, I keep a card immunization record in the office and have the parents keep another record for future reference so that they will be able to tell just what this child has been immunized against. One often sees a child whose parents do not know about the test. They will say that a Doctor "stuck a needle" in them but they don't know what was given.

Let's cooperate with the public in trying to immunize these children against communicable disease in every instance possible.

BASIC CHANGES IN TUBERCULOSIS CONTROL*

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Our methods of diagnosis, treatment, and prevention of tuberculosis have been so improved in the past few years that the ultimate control of this disease has become relatively simple. The methods used in the diagnosis of tuberculosis are now so standardized that any properly equipped physician can in a very short time determine whether a given patient has tuberculosis in a clinical form. The first step consists of the administration of the tuberculin test, which serves as a fine screen to detect nearly everyone who has the germs of tuberculosis in the body. The subcutaneous test which Koch employed about 1890 is rarely used. The epidermal test which was presented by Pirquet about 1907 has been extensively used but is giving way to the intracutaneous test developed by Mantoux in 1908. This test is easily administered, is inexpensive, harmless and highly specific. Koch's Old Tuberculin has been in common use for many years.

*Presented before the Annual Tuberculosis Conference of the Florida Tuberculosis and Health Association, Orlando, Florida, April 2, 1935.

Inasmuch as it is tuberculo-protein to which the tissues become sensitive, research workers such as Long, Seibert, and Dorset, have developed a testing material containing only the protein of the tubercle bacillus. The final product is known as Purified Protein Derivative and can now be obtained through the commercial drug houses. This is a standardized preparation which may completely replace Old Tuberculin in the next few years. The only serious objection now being voiced is its cost, which is considerably greater than that of Old Tuberculin.

When the tuberculin test is found to be positive, it is excellent proof that the positive reactor has been exposed to a person or an animal eliminating tubercle bacilli. Moreover, it is good evidence that at least the first infection type of tuberculosis has developed somewhere in the body. These are very significant facts. Often the positive reactor does not know the source of his exposure since tuberculosis so frequently exists in the bodies of persons in an unsuspected form. Therefore, the making of careful examinations of the close associates of the positive tuberculin reactor frequently leads to the finding of an open case of tuberculosis not previously known to exist. For example, in the schools of Cleveland last year by examining the relatives and other associates of the children found to react positively to the tuberculin test, 46 cases of frank pulmonary tuberculosis were detected for the first time. Much attention is now being paid even to the health of the pre-school child, through the Summer Round-up, and in 1934 the examination blanks had space for the report of the tuberculin reaction.

A positive tuberculin reaction gives us no evidence as to the presence of reinfection type of clinical tuberculosis but inasmuch as practically all such cases react positively to the test, a most careful examination for clinical disease should be made of all children and adults found to react positively. Such an examination should be made regardless of the weight or general appearance of the individual. It is not uncommon to find clinical tuberculosis developing in the bodies of persons who appear to be in perfect health.

The second step consists of x-ray film examination of the chests of persons found to react positively to the tuberculin test. While the x-ray film will not reveal very small lesions, nevertheless, it will often bring to light evidence of disease before there are any abnormal physical signs or symptoms. The finding of shadows on the x-ray film in the chest of a person who reacts positively to the tuberculin test by no means constitute a diagnosis of tuberculosis. Such shadows may be due to a number of disease conditions, or if due to tuberculosis may be of no clinical significance. However, the x-ray has located a lesion which should be most carefully studied by the clinician, who takes a careful history of any exposure to tuberculosis, of any symptoms past or present, makes a careful physical examination, examines in the laboratory any sputum which the patient raises, even though he believes it is only cleared from his nose and throat. In recent years, the Arneth-Schilling blood count, modified by such workers as Medlar, as well as the red-cell sedimentation test, have been found to be of considerable value in determining whether a lesion located by x-ray film is of a progressive nature.

If, at the time of the first examination, no clinical manifestations can be detected, patients with such x-ray shadows should be kept under careful observation. X-ray films should be made from time to time; and the shadows compared with those previously observed to determine whether they are changing in size or character. In addition to this, very careful observations should be made as to the appearance of symptoms, physical signs, laboratory findings, etc. The ideal procedure would be to administer the tuberculin test to everyone in a given community and the above outlined examination provided for all of the positive reactors. While it is quite probable that such a procedure will be employed in the future, we are not yet organized so this can be done. However, there are certain groups of persons who can be examined in this manner, such as all the members of families where a case of tuberculosis is known to exist, Figures 1 and 2, all the teachers and other employees of school systems, as well as school children, all the students in colleges and universities, employers and employees in industry, etc. In fact, among the groups mentioned, such work is well advanced in some parts of the country. There is no longer reason why children in public or private school systems, why students in colleges or universities, why teachers or members of faculties or other employees, should be going about their work with tuberculosis, which they are transmitting to their associates.

In the control of tuberculosis in schools, there

are two problems: that of the disease being spread from teachers, faculty members, and other employees to the students; and that of the students spreading disease to the teachers, etc. There is very little danger of children under the age of ten years spreading tuberculosis, but after that age the disease is quite frequently seen in a form which makes it dangerous for all associates. The enlistment of the educators in the campaign against tuberculosis is a great step toward the ultimate eradication of this disease.

Hospitals for the insane have recently been found to be sources of the spread of tuberculosis. The proper control of the disease through isolation, etc., in such institutions will prevent its spread to nurses, physicians, and other employees, as well as to other patients.

Evidence has accrued in recent years to show that many of our general hospitals and some of our sanatoriums are contaminating large numbers of visitors, students of nursing and medicine, as well as graduates in these professions, and other patients. The examination of all persons admitted to general hospitals for whatever cause, to determine whether tuberculosis in a communicable form co-exists, will control this situation if strict contagious technic is practiced in rooms and wards of general hospitals where such patients are treated and in whole institutions for the tuberculous. It cannot be long until the tuberculous patient will be treated with a technic that is no less rigid than that of other communicable diseases, such as diphtheria.

When one sees infants die from highly fatal tuberculous meningitis and knows full well that these deaths are unnecessary, it inspires one to use every bit of energy possible in bringing to the public, the great need for examinations for tuberculosis of all expectant mothers and their immediate families. Tuberculosis is not inherited; indeed, only very rarely is it even a congenital disease, but it is one that the infant and the adult alike contract through coming in contact with tuberculous persons. To allow a mother to go through pregnancy and delivery with definite tuberculosis, which has never been suspected, is a serious reflection upon all health workers and upon health education. Yet every year a good many infants die of tuberculous meningitis during the first year of life. Nearly always after the infant is dead, and an attempt is made to find the source of the disease, some close associate, and often the mother, is found



Figure 1.

FIG. 1. E. R. S. Female. Age 65 years. Made from an x-ray film of the chest taken on May 15, 1934. Shows evidence of far advanced pulmonary tuberculosis, involving both lungs. Sputum contains tubercle bacilli.



Figure 2.

FIG. 2. J. S. Female. Age 20 years. Daughter of woman whose chest is seen in Fig. 1. Made from an x-ray film of the chest taken on March 12, 1935. Shows evidence of disease involving the left first interspace.



Figure 3.

FIG. 3. H. H. Female. Age 6 years. Father had died of tuberculosis. Tuberculin test positive. Made from an x-ray film of the chest taken on May 2, 1922; shows Ghon tubercle formation right upper lobe, partially obscured from view by shadow of first rib. There are also calcium deposits in the right helium region and in the paratracheal lymph nodes on the same side. This child had no symptoms of tuberculosis.



Figure 4.

FIG. 4. Made from an x-ray film of the same chest as seen in Fig. 3, taken on April 26, 1935. Shows evidence of far advanced pulmonary tuberculosis, involving both lungs.

to have tuberculosis in a transmissible form. Through the pernicious custom of fondling and kissing infants, the disease is transmitted to their bodies. There is no excuse for this loss of life in a day when we know how to detect tuberculosis in the bodies of expectant mothers and other members of the household.

Already in some charity clinics in this country, every woman who presents herself for obstetrical care is referred to the chest department, where tuberculin tests are administered and x-ray films are made of the chests of all the positive reactors. When an expectant mother is found to have tuberculosis in a form which may be transmitted to the infant after birth, it is often in such an early stage that it may be treated successfully without interfering with pregnancy. Such a mother delivers an infant that is just as healthy and has just as good an expectancy of life as the infant of a mother who has never had tuberculosis. However, immediately after birth the infant of the tuberculous mother is not allowed to have any more contact with her unless the disease has been brought under control before delivery or until it can be brought under control after delivery. If the mother's disease is too advanced to be treated successfully, she is still allowed to go through pregnancy and she, too, delivers an infant with no health hazard as far as tuberculosis is concerned. Such an infant is best provided for in a foster home, where no member of the family has tuberculosis in a communicable form. As the public becomes aware of this simple procedure and the nursing and medical professions everywhere put it into practice, deaths among infants from tuberculous meningitis will decrease to an insignificant number.

We have learned which groups of persons of a community will provide most of the tuberculosis load of the future. At one time, we thought that those persons who react positively to the tuberculin test were protected and that very few, if any, of them would later fall ill from tuberculosis. This belief was based upon opinion without sufficient evidence to support it. Actual observations have shown that the girls and boys who react positively to the tuberculin test are many times more likely to fall ill from tuberculosis, before they reach their majority, than girls and boys who react negatively to the test, Figures 3 and 4. In fact, among 1,000 examined in this country at the average age of

eight years in 1921 and 1922, of those who could be traced in 1934, it was found that 9.65 per cent who were originally positive were ill or had become ill, whereas, of those who were negative to the test in 1921 and 1922, only 1.08 per cent had developed tuberculosis which caused illness. A fact even more discouraging than this is that these girls and boys have only reached the average age of about twenty-one years, and we know that tuberculosis mortality does not reach its peak until about twenty-five years. Thereafter, it slowly decreases until forty-five years, during which time it is the first cause of death in the human family in this country. Obviously, there is another twenty-five years in the lives of these girls and boys during which tuberculosis may develop.

Once a definite diagnosis of pulmonary tuberculosis is made and the disease is found to be of a progressive nature, no matter how minimal or how extensive the lesions, treatment should be instituted at once. Here one finds that methods of treatment have advanced as rapidly as methods of diagnosis. Mystery and superstition have been overthrown and in their place have come sane methods of treatment based upon adequate observation and experience. Food faddists have also been relegated from the field so that we should no longer hear of the patient who has eaten 15,000 raw eggs, or who has drunk a gallon of milk daily for weeks, or who has lived on a grape diet while losing twenty-five pounds in weight, or who has eaten enough bran to necessitate an operation for obstruction of the intestinal tract. There is nothing specific in any single food, yet wholesome food in the proper amount and containing all the necessary daily requirements of the body is extremely important in the treatment of tuberculosis. The "fresh air" faddists have been defeated through scientific contributions of experts who have learned the atmospheric conditions in which the body functions best, both in health and disease. The ventilating engineers have entered the field and have already made available the ideal condition for both homes and hospitals where tuberculous patients are treated.

The advice of two or three decades ago which usually resulted in the patient giving up his work, going to the country, wandering about in the open air, etc., is now recognized as worthless. The later advice, which resulted in the patient giving up his work, becoming a strict bed patient,



Figure 5.

FIG. 5. J. B. Male. Age 20 years. Made from an x-ray film of the chest taken on July 17, 1933. Shows evidence of extensive pulmonary tuberculosis, involving the left lung. Definite symptoms were present.



Figure 6.

FIG. 6. Made from an x-ray film of the same chest as seen in Fig. 5, taken on Oct. 28, 1933. Shows left lung collapsed by artificial pneumothorax. This is a case of ambulatory pneumothorax treatment; that is, the period of strict bed rest was limited to two or three weeks in the home, while the collapse was being instituted. Since that time this patient has had no cough, sputum, or other symptoms of tuberculosis, and has had a full working capacity.

and there day after day and month after month trusting that he would develop enough resistance to control his disease, was better but the result was more often failure than success.

This advice was based upon the rest which the diseased lung would receive. We continue to breathe, even though we are lying in bed, at about the rate of eighteen times per minute. This amounts to approximately 25,000 times in a day. How can any organ which moves with clock-like regularity at this rate obtain much rest? Immobilization is the only answer to the demand for rest. Nature had proved its effectiveness through locking the diseased joint, collapsing the diseased lung, et cetera. Therefore, physicians learned to do this artificially. The cast was developed as well as surgical procedures, to immobilize the diseased joint.

A method was devised of collapsing the diseased lung by introducing air into the pleural cavity, which proved to be the beginning of a complete change in the methods of treating pulmonary tuberculosis. This method proved to be valuable in many hopelessly advanced cases of tuberculosis, but often it failed because of the long duration of the disease, its extensiveness, and adherence of the lung to the chest wall. Artificial pneumothorax was then extended to the cases which by reason of less disease, fewer symptoms and no adhesions, were better risks. The results were definitely better. Only recently artificial pneumothorax has been extended to the very minimal, progressive case of tuberculosis, and here the best results of all are obtained. Obviously, the smaller the area of disease, the less destruction of tissue and the more normal lung for breathing when the treatment is concluded. In only one-third of the present diagnosed minimal cases of pulmonary tuberculosis are tubercle bacilli being disseminated to others. If artificial pneumothorax is instituted in such cases, two-thirds have not yet broken down so as to spread their disease, and the most of them can be prevented from breaking down so as to be of danger to their associates. Many of those who are already eliminating bacilli have their disease brought under control quickly and they, too, become safe associates.

A most encouraging fact about artificial pneumothorax in minimal cases and even some more advanced cases is that since the patients are good risks; are not emaciated; and often have no symptoms, it is not necessary to take them out of their work for more than a few weeks to two or three months, and some not at all, Figures 5 and 6. Most employers are willing to grant leaves of absence for such brief periods of time. Thus, the patient's morale is practically undisturbed. He remains a part of the active world on a treatment that is safe to him and his associates. As soon as we arrive at the stage when tuberculin tests are administered to large numbers of people and x-ray films are made periodically thereafter of all the positive reactors, we will find many more cases of tuberculosis in the minimal stage than we have found in the past. This will mean successful treatment for the majority of them.

For those persons whose disease has become too advanced or whose lungs have grown fast to the chest wall, we still have methods of immobilizing the lung which are very effective. One such method consists of interruption of the phrenic nerve on the side of the disease which results in elevation and paralysis of the half of the diaphragm it supplies. The high position of the diaphragm reduces the capacity of the chest cavity on that side; hence, the lung is reduced in volume and its movements are greatly reduced in breathing. In this manner adequate rest of the lung may be obtained, to result in control of the tuberculous disease. However, this alone does not hold the possibilities of success that artificial pneumothorax does.

When interruption of the phrenic nerve fails, the next step is the most drastic method of treatment now employed. It is known as extrapleural thoracoplasty and consists of removal of the ribs on the side of the disease. When this supporting bony framework is gone, the whole chest wall collapses down upon the lung. The diseased areas in the lung collapsed in this manner often come under control by the localized rest provided by the collapse.

Although large numbers of persons have been restored to fairly comfortable living and many to good working capacities by extrapleural thoracoplasty, it does not offer the possibilities that artificial pneumothorax does. In this case the collapse is permanent; the lung can never be used again. In artificial pneumothorax, the collapse is temporary so that after the disease is controlled, the lung is allowed to re-expand, and all of that part which was not destroyed by disease before the collapse was begun, may function in respiration. Moreover, as the public becomes

aware of the new viewpoint on tuberculosis control and the accurate methods of diagnosing the disease, there will be fewer cases allowed to become so advanced that thoracoplasty is necessary. There will be a preponderance of cases detected early when artificial pneumothorax will control the disease with very little inconvenience to the patient and almost no interference with the activities of life.

In 1933, there were 1,043 deaths from tuberculosis in Florida. There are only 180 beds set aside for the tuberculous in this state. Therefore, it would appear that there is need for a state sanatorium, where open cases of tuberculosis who cannot be cared for in their communities because of lack of funds, extent of disease, etc., can be isolated and treated. You are in a position to profit from the mistakes certain states have made in overbuilding their sanatorium capacities, as well as providing for groups of cases who do not need sanatorium care, such as children with the first infection type of disease. The morbidity as well as the mortality from tuberculosis is decreasing quite fast in the United States and, therefore, the apparent sanatorium needs of today may be cut in half or more within the next five years. Such factors should be carefully studied before building an institution. In this connection, local general hospitals are already playing a considerable role in the tuberculosis program. Last year in the United States more than 37,000 tuberculous patients were treated in such institutions. This is nearly half of the combined capacity of the sanatoriums of this country. At the present time, there are 2,056 vacancies in the general hospitals of Florida. Doubtless many of them could be had for the poor at a cost that would not exceed that of maintenance in a sanatorium. The great advantage is that no building is necessary, no time is lost, and it is only a matter of securing appropriations for the maintenance of patients. If your organization could arrange to have taken out of their communities even 1,000 open cases of tuberculosis and have them isolated and treated in these general hospital beds, a preventive measure of the first order would be accomplished. This is not a new idea. It has been carried out very successfully in Detroit.

I was very favorably impressed with the work in progress in Jacksonville to provide convalescent homes for colored patients with advanced tuberculosis, where they can be made comfortable as long as they live and the spread of their tubercle bacilli will be prevented. The portable cottage which is being advocated in South Carolina, where because of lack of hospital facilities, the colored tuberculous patient with advanced disease can be isolated in part, at least, from his family and remain on the same premises seems to be very much worth while. After all, the chief object of hospitalization, whether it be in a sanatorium or a general hospital, is to prevent spread of tubercle bacilli.

One of the very encouraging facts that has been added to our knowledge in recent years, is that pulmonary tuberculosis in chronic clinical form rarely attacks the bodies of children under the age of ten years. It is true that children become infected with tubercle bacilli and develop the first infection type of disease, as manifested by a positive tuberculin reaction, but this is a very benign form of tuberculosis and, in the majority of children infected, causes no illness. While it is true that a small percentage of contaminated infants and young children develop acute and highly fatal forms of reinfection type tuberculosis, such as miliary disease and meningitis, soon after their tissues become allergic, there is no evidence that hospitalization or any other form of treatment will prevent these occasional occurrences once the infant's body is contaminated. It is also true that infants and children who develop the benign first infection type of tuberculosis are many times more likely to develop the reinfection destructive type of disease during the teen ages and in subsequent years, yet there is no evidence to show that sanatorium care, preventorium residence, summer camps, etc., have any influence whatsoever upon the first infection type of tuberculosis. Therefore, what we thought was a staggering problem a few years ago, namely the building of institutions for children, has melted away. To be sure, the occasional child under the age of ten years who develops the chronic, reinfection type of tuberculosis may need institutional care but this number is so small as to constitute no serious addition in our building problem. In fact, some sanatoriums in this country which had been equipped with buildings for children have abandoned them and converted them into much better use, namely, taking out of the communities the open cases of tuberculosis, isolating them in these buildings, and leaving the children in the communities in a normal environment.

We frequently see photographs of groups of children from preventoriums, children's buildings of sanatoriums, summer camps for tuberculous children, etc., which are used as an appeal in raising money to fight tuberculosis through the sale of Christmas seals or in seeking legislative appropriations. In the light of the actual facts concerning the necessity of treatment of infected children in institutions and the actual dangers attendant upon institutionalization of children, this is propaganda in the worst sense of the word. When the public becomes acquainted with the facts, this propaganda is likely to act as a boomerang. How much better it would be to show photographs of children under happy and safe surroundings in their homes or in foster homes and alongside a photograph of the far advanced cases of tuberculosis who have been removed from their homes and are now being isolated and treated in the sanatorium, in order that the children may be protected. This would give the public the true concept of tuberculosis control.

To take all cases of tuberculosis as soon as detected by their private physicians away from them and place them in tax-supported institutions is unwise. The medical profession of the nation has suffered greatly from just this practice in many parts of the country. Therefore, whenever the tuberculous patient's home conditons are good or when the patient can afford care in a private hospital and the physician in charge is well informed on the contagiousness of the disease, the modern methods of treatment, etc., no attempt should be made to remove that patient from the physician's practice. The patient will receive as good or better care than he could receive in any tax-supported institution and the physician's interest in tuberculosis control will be maintained.

The prevention of tuberculosis has likewise undergone great advances in recent years. No specific agent has been found such as we have in diphtheria and some of the other communicable diseases. Calmette's vaccine is still being used very extensively in some European nations, while others have placed a very definite ban on it. This vaccination consists of introducing into the human body, large numbers of tubercle bacilli which have been rendered avirulent through laboratory methods. There are two main objections to such a method which will probably prevent it from ever being universally accepted. The first is that of introducing living tubercle bacilli into the body. Even though they are apparently harmless at the time, bacteriologists in various parts of the world have called attention to the danger that they may regain their virulence after living a long time in the body and thus become very dangerous. The second objection is that even though they are avirulent they cause the tissues of the body to become sensitive to tuberculo-protein. This is looked upon by many as a definite hazard if virulent tubercle bacilli from outside sources are taken into the body. In this country, our method of prevention, since tuberculosis is a communicable disease, is meeting with such success that we do not feel the need of vaccination unless one can be found that is free from all danger, either present or potential.

The problem of tuberculosis among servants in the home and those who are employed to prepare and handle food in hotels and other public eating places has been a very serious one in this ocuntry and I am inclined to believe that it is most serious in the Southern states where the colored people take such an active part in this type of work and where tuberculosis is so prevalent among them. Most certainly the medical profession would do well to recommend that every family, hotel, etc., require very careful examinations for clinical pulmonary tuberculosis of all persons before they are employed and periodically thereafter as long as they are employed.

Not many years ago, many hotels and railroad companies did excellent educational work in tuberculosis control when they carried on their menus a statement to the effect that all milk served was from tuberculosis-free or tuberculin tested cattle. They could now do a fine service by announcing on menus that all of their employees are free from tuberculosis in a communicable form. If such a procedure were instituted by great business organizations, the idea would soon reach the American home that there, too, not only the members of the household but everyone who is employed in the home should be adequately examined for this disease.

We have a demonstration of tuberculosis control such as the world has never before seen; it is the campaign which has been conducted by the veterinarians and closely allied groups. The veterinarians have used the tuberculin test to determine just which animals harbor tubercle

bacilli. They have then slaughtered the animals reacting positively to the test, regardless of general appearance. Often animals which appeared to be in perfect health were slaughtered for no other reason than a positive tuberculin reaction. The veterinarians knew that in the bodies of all of these animals there were living tubercle bacilli. They knew that not all the animals so contaminated would fall ill and die from tubercuosis, but they also knew that some of them would. Inasmuch as they had no test or method of examination to determine which animals would fall ill they destroyed all. The result is that already in twenty states and in more than two-thirds of all the counties in the United States, the incidence of tuberculosis among cattle has been reduced to one-half of one per cent or less. In some counties the disease has been completely eradicated and for many years not a single animal has been found to react positively to the tuberculin test. It has been truthfully said that from the standpoint of tuberculosis the calves in these counties are safer than babies.

For a long time we feared tuberculosis among animals because it was so frequently transmitted to children, many of whom were deformed and crippled for life through the attack the bovine type of tubercle bacillus made upon their bony framework. Wherever the veterinarians have had an opportunity to carry out their program there is no longer such danger to the human family. Now the veterinarian fears that human beings with tuberculosis will transmit their disease to the cattle.

Whenever the adoption of the veterinarian's tuberculosis prevention and control among human beings is recommended, someone smiles and says you cannot slaughter people because they react positively to the tuberculin test or even when they have far advanced disease. No tuberculosis worker has ever suggested such a procedure. But every well-informed worker now recommends that we do area testing just as the veterinarian does and by this means find practically all of the persons whose bodies are contaminated with tubercle bacilli. Those who are not ill and have no disease that threatens their immediate future or makes them unsafe for their associates are kept under close observation. They are examined periodically, including x-ray films of their chests. Although this method is more expensive and more laborious, it is almost equal to the veterinarian's method of slaughtering animals as far as tuberculosis control is concerned. For those who have progressive tuberculous disease, whether or not they are ill, we have three methods in dealing with them which are humane and which combined are just as effective as the veterinarian's method. These methods are: first, adequate treatment of those whose disease is not too advanced; second, isolation of those who are spreading tubercle bacilli and those who cannot be treated successfully; third, education concerning the communicability of tuberculosis for all.

Thus, our methods of preventing tuberculosis are on a sound basis. They are going forward with unbelievable rapidity when one considers the magnitude of the problem and the short time they have been in effect. He who predicts that even under ideal conditions tuberculosis could be completely eradicated from the human family in a decade or so is not a true student of tuberculosis. But since it is within the power of man to free the human family from any communicable disease, it is safe to state that if our present methods of prevention are employed as they should be, the time will come when future generations will be able to raise their domestic animals for food and for profit without loss from tuberculosis and when they, themselves, will be able to live out the span of life with no interference from tuberculosis.

ADENOMA OF THE THYROID*

CLAUDE ANDERSON, M.D.,
Orlando.

Compared to other regions of the country, there is a relatively small number of native Floridians afflicted with goiter; however, due to the fact that our state is rapidly becoming populated by people from all sections of the country we are seeing more and more of these disturbances in the thyroid gland.

All too often do we see nodular growths in the thyroid being completely ignored and neglected until distressing symptoms arise that make medical attention necessary. Perhaps this is because the nature of the enlargement is not understood and the many complications which might occur are unknown. Those who have this type of goiter frequently look upon it as an innocent affair and feel that nothing should be done about it.

*Read before Orange County Medical Society, March 20, 1935.

What a contrast this is to the present day view of growths elsewhere in the body. Due to extensive educational campaigns against cancer the public is becoming aware of the dangers that lie in simple tumors and of the possibility of these growths undergoing malignant changes. This is shown by the fact that women with breast tumors are tending to seek professional advice earlier because they have learned to fear such tumors and, by having them removed at an early date, have appreciably reduced the mortality in breast cancer.

The same concern should be shown regarding growths of the thyroid but it is not at all unusual to find a firm and nodular goiter in one who has been advised to wait for further developments before considering its removal. Because the goiter is small and not disfiguring is no reason to believe that complications may not arise. In spite of the fact that these small tumors of the thyroid have long been looked upon as innocuous affairs it has been shown that chances of undesirable changes taking place are in reality greater than in breast tumors. The more important of these complications are cancer, secondary toxicity, pressure on the trachea and other important structures of the neck, extension into the chest, hemorrhage and abscess.

Statistics taken at large thyroid clinics such as Lahey's, Crile's and Mayo's show that approximately two per cent of all thyroid cases are malignant. If we omit the group of patients who have the type of goiter in which cancer very rarely occurs such as the goiter of adolescence, the exophthalmic goiter and various types of inflammatory enlargement of the thyroid and include only those cases of adenomatous goiter then the incidence of cancer would be from five to ten per cent. It is the concensus of opinion of goiter authorities that 90% or more of the cancers of the thyroid are preceded by adenoma. After cancer once develops to the stage where it produces its typical symptoms the chances of cure from any mode of treatment are very remote. Were there no other complications to be considered the probability of cancer alone is sufficient to warrant the medical profession strongly advising the early removal of these precancerous lesions.

Secondary toxicity occurs in 25% to 30% of adenomatous goiters. The symptoms of toxicity develop insidiously and progress slowly, the average length of time from onset of symptoms to the time of operation being about fifteen years. After this length of time the disease, the true nature of which may not have been recognized, is often associated with marked degenerative changes in other important organs of the body, with heart irregularities and beginning heart failure; this adds considerably to the operative risk and diminishes greatly the prospect of complete cure. The usual symptoms of toxicity are: slowly failing health, gradual and progressive loss of weight, irregular and rapid heart action, nervousness with tremor, increased susceptibility to heat and profuse sweating. It is rare that all of these symptoms will be found in any one case and occasionally we are confronted with great difficulty in making a diagnosis. Many such patients, due to the prominence of the heart symptoms, are led to believe that they have heart disease and are often treated for such. It is this latter group of patients that largely make up the class of thyrocardiacs and apathetic hyperthyroidism which Lahey has so aptly described. It is this group which account for the major portion of the operative mortality. However, with careful preoperative treatment and with conservative graded surgery this type of patient can be carried safely through surgical treatment to recovery with an extremely low mortality.

Pressure on the trachea and other important structures in the neck occurs to some extent in practically all nodular thyroid growths. The degree of pressure depends on the location and the size of the adenoma; thus various degrees of obstruction to breathing, hoarseness, coughing, changes in voice, difficulty in swallowing and of pressure on the veins will be seen in a large series of cases. The removal of the tumor however usually allows these structures to return to normal conditions.

Probably 50% of nodular goiters show some extension into the chest either under the clavicle or under the sternum; however only a very small number (2-3%) will become entirely intrathoracic. The majority of these are adenomas or cysts that result from adenomas which have become liquefied. The dangers of allowing nodular tumors of the thyroid to become intrathoracic are quite obvious. There may be marked pressure on the trachea causing such a degree of narrowing and distortion as to seriously interfere with breathing. Occasionally there is pressure on the large veins of the neck, causing a marked venous stasis.

In the diagnosis of intrathoracic goiter the use of x-rays are invaluable because of the fact that often nothing significant can be palpated in the neck. Occasionally we see a patient with all the symptoms of a toxic goiter but in whom we are unable to feel an enlarged thyroid gland; in such cases x-ray should be used as a diagnostic aid. All nodular thyroid growths should be x-rayed before operation to determine whether there is an extension into the chest which may or may not be attached to the portion in the neck and which in some cases might be overlooked at operation without the advantage of x-ray.

Hemorrhage, while rare, the incidence being not over one to two per cent, occasionally occurs in thyroid adenomata and at times may cause very alarming symptoms. Such cases may be confused with cancer or acute inflammatory conditions of the thyroid but by a careful history these conditions should be ruled out. Such an accident may cause sudden severe pain and greatly interfere with breathing and swallowing. Should the hemorrhage occur in an adenoma lying in the chest it can readily be seen that a serious surgical emergency would arise due to the sudden pressure on the trachea and the subsequent interference with breathing.

Abscess formation and acute inflammation are quite rare but do occasionally occur in discrete adenomata. We sometimes find that after a hemorrhage or small repeated hemorrhages in an adenoma that the tumor becomes liquefied, the contents become infected and an abscess forms.

For many years it has been known that iodine exerts a marked influence on the function of the thyroid gland but it has been clearly shown that Lugol's solution or any other preparation containing iodine will not cure nodular goiters or any other type except the colloid type of adolescence. Kocher in 1907 warned against the use of iodine in the treatment of goiters showing signs of activity for fear of producing more serious results, and he stated emphatically that treatment with iodine was ultimately more dangerous than operation. In 1917, due to the efforts of Marine and Kimball, iodine was used in very small doses for the prevention of endemic goiter in man. It is now used in goiterous districts in the form of iodized salt as a prophylactic.

In 1923, Plummer drew attention to the beneficial use of iodine when used before operation in large enough dosage to cause a remission in the disease and a marked lowering of the basal metabolic rate thereby making the patient a better risk for operation. The intensive preoperative treatment of patients with toxic goiter has rendered the operation a great deal safer and has prevented to a great extent the postoperative crises that were so prone to occur in the earlier history of thyroid surgery.

Aside from its use in the colloid goiter and as a prophylactic in endemic goiterous areas and as a preoperative measure iodine has no place in the treatment of goiter and when so used causes untold damage and great suffering to unsuspecting goiterous patients throughout the country. Under present conditions it is not only prescribed by some physicians but by druggists and even by the laity, either in the form of the tincture or solution of metallic iodine, of tablets, of ointments, salves, iodides or table salt. The characteristic effect of the drug is produced regardless of the manner in which it is introduced into the body.

There is no convincing evidence that iodine has ever had a beneficial effect on a true adenoma in the way of causing its disappearance or in retarding its development; but in the experience of many goiter authorities iodine frequently activates a quiescent adenoma rendering it toxic with all the symptoms of secondary toxicity.

The only safe method of treating discrete adenoma of the thyroid is by surgical removal. Before complications develop it is one of the simplest of surgical procedures in experienced hands. After the complications of toxemia, cancer or extension in the chest once occur the operation is rendered more difficult and recovery less certain.

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DOCTORS' SUMMER GRADUATE COURSE

The week of June 22 through 27 has been announced as the time for the Fourth Annual Graduate Short Course at Gainesville for doctors of medicine in Florida. The schedule of courses will be essentially the same as that of June, 1935, except that the six hours occupied last year by the lectures on Orthopedic Surgery and Venereal Diseases will this year be filled by a course in Neuropsychiatry. The other courses will be Medicine, Pediatrics, Obstetrics, Gynecology, and Surgery, as before.

So popular was the symposium on Malaria last June that, in response to many requests, the committee is arranging a symposium on Respiratory Diseases for Monday evening, June 22, and one on Fractures for Thursday evening, June 25. Tuesday and Friday evenings, June 23 and 26, respectively, will be devoted to round table discussions, where each lecturer will be given twenty minutes in which to answer questions previously turned in. Formerly these discussions were held during the noon hour, but because the doctors attending the course preferred to keep the luncheon period open for rest and relaxation, the evening programs have been scheduled. During the day the hours for the lectures will be unchanged except that there will be a short recess between the two afternoon periods.

Physicians who attended last year's course will learn with pleasure that three of the lecturers have consented to return for this year's session. They are Dr. O. W. Bethea, Professor of Clinical Medicine at Tulane University, who will present the course in Medicine; Dr. Charles Reid Edwards, Professor of Clinical Surgery at the University of Maryland, who will deliver the Surgery lectures; and Dr. Emil Novak, Associate in Gynecology at Johns Hopkins Medical School, who will give the lectures on Gynecology again.

Newcomers to the teaching staff of the short course will be Captain Walter S. Jensen, M. C., Director of the Department of Neuropsychiatry at the School of Aviation Medicine, Randolph Field, Texas, who has agreed to give the course in Neuropsychiatry; and Dr. Otto Schwarz, Professor of Obstetrics and Gynecology at Washington University School of Medicine, St. Louis, who will present the course in Obstetrics.

The committee in charge of arranging the short course this year is made up of the following members: Dr. T. Z. Cason, Jacksonville, chairman; Dr. George L. Cook, Tampa; Dr. G. C. Tillman, Gainesville, University of Florida representative, and Dr. Hugh West, DeLand.

PRE-CONVENTION MEETING

At the call of the president, Dr. Herbert L. Bryans, the Pre-convention Meeting of the Florida Medical Association was held in Jacksonville, at the Carling Hotel, February 23, 1936. During the forenoon, a number of committee meetings were held.

The Executive Committee took up a number of routine matters and also heard from Mr. D. U. Wilder, a representative of the P. & O. Steamship Company, and Dr. J. Knox Simpson, chairman of the Committee on Boat Trip. The Steamship Company, after checking applications agreed to proceed with the boat trip as originally proposed. Since the boat trip was decided by the majority of the House of Delegates at its meeting in May, 1935, the Executive Committee authorized the official announcement that the Sixty-third Annual Meeting of the Florida Medical Association would be held aboard ship.

The Committee on Scientific Work was in session for several hours, reviewing thirty applications from doctors who wished to present papers in the session of the Scientific Assembly. After careful deliberation, thirteen papers were selected after giving due consideration to the titles of the proposed papers and the geographical location of the applicants.

The Committee on Post-Graduate Short Course held a meeting and completed plans for the course which is to be held in Gainesville, June 22-27, inclusive.

The Committee on Public Relations held a meeting and made further plans for broadcasts.

At 1:00 p. m., a general session was held at which time the chairman of the various committees made preliminary reports and the councilors present read their reports. Councilor reports received by mail were read by title and referred to the secretary for publication in the Journal. Dr. Julius C. Davis reported for the Committee on Legislation and Public Policy and Dr. W. A. McPhaul, the new State Health Officer, was asked to make a few remarks. The meeting was presided over by the president, Doctor Bryans.

At 3:00 p. m., a second session was held in the ball room of the Carling Hotel at which Doctor Bryans made a short address and introduced the guest speaker of the occasion, Dr. James S. McLester, president of the American Medical Association.

This Pre-convention Meeting was well attended, having representative doctors from all parts of the state. Those who registered at the luncheon were:

Anderson, L. M. ..... Lake City
Ashton, W. L. ..... Umatilla
Bryans, Herbert L. ..... Pensacola
Cason, T. Z. ..... Jacksonville
Christ, C. D. ..... Orlando
Copeland, S. M. ..... Jacksonville
Davis, Julius C. ..... Quincy
Dozier, H. C. ..... Ocala
Driskell, S. E. ..... Jacksonville
Duke, R. R. ..... Tampa
Feaster, O. O. ..... St. Petersburg
Gates, Hubbard ..... Bradenton
Gilmer, E. S. ..... Tampa
Harkness, R. B. ..... Lake City
Harris, William G. ..... Jacksonville
Holloway, Luther ..... Jacksonville
Ira, Gordon H. ..... Jacksonville
Jelks, Edward ..... Jacksonville
Johnston, J. K. ..... Tallahassee
Klein, Lawrence A. ..... Jacksonville
Limbaugh, Louie ..... Jacksonville
Lowry, B. W. ..... Tampa
Lyerly, J. G. ..... Jacksonville
McDuffee, T. M. ..... Manatee
McKinnon, D. A. ..... Marianna
McLester, James S. ..... Birmingham, Ala.
McPhaul, W. A. ..... Jacksonville
Mallory, Meredith ..... Orlando
Manning, W. S. ..... Jacksonville
Moor, F. Clifton ..... Tallahassee
Morris, Kenneth A. ..... Jacksonville
Page, Grady ..... Orlando
Page, W. C. ..... Cocoa
Palmer, Henry E. ..... Tallahassee
Palmer, T. M. ..... Jacksonville
Peek, Eugene G. ..... Ocala
Porter, H. W. ..... Jacksonville
Pound, J. H. ..... Chattahoochee
Quasser, A. B. ..... Jacksonville
Richardson, Shaler ..... Jacksonville
Robinson, Leigh F. ..... Ft. Lauderdale
Rollins, C. D. ..... So. Jacksonville
Sanderson, Raymond ..... Jacksonville
Shaw, W. M. ..... Jacksonville
Spiers, W. H. ..... Orlando
Swift, E. C. ..... Jacksonville
Taylor, H. Marshall ..... Jacksonville
Teeter, E. H. ..... Jacksonville
Thompson, Stewart G. ..... Jacksonville
Tillman, George C. ..... Gainesville
Turberville, J. S. ..... Century
Tyler, L. V. ..... So. Jacksonville
Upchurch, N. A. ..... Jacksonville
Walker, Harrison A. ..... Miami Beach
Webb, C. C. ..... Pensacola
Wells, J. Ralston ..... Daytona Beach
Wilkinson, Albert H. ..... Jacksonville

RADIO BROADCASTS, 1935-1936

The following broadcast was arranged by the Public Relations Committee of the Florida Medical Association and given over station WRUF, Gainesville:

INTRODUCTION TO MEDICAL ECONOMICS, I*

J. S. Turberville, M.D.,
Century.

I have come to talk to you about doctors and some of their affairs.

In the dim past the priests exercised the functions of the medical men. By and by some priests became more and more attracted to the medical side of their duties until there was actual separation and the medical profession was born. Now the medical profession is one of the most learned, and highly trained of all the professions.

There are certain customs among doctors and laymen that no doubt had their origin in the beginning, that is to say when priests practiced medicine. I refer to one custom in particular, namely free service to the sick poor. The educational costs, equipment, and living conditions of doctors have created demands that cause real hardships and when service to the sick poor is added his burden, of course, is increased.

Doctors pay taxes the same as other citizens and are therefore morally no more under obligations to treat the indigent free of charge than the groceryman, the baker, or the butcher, should furnish groceries, bread or meat free. Nevertheless, there is a widespread notion that they should. Doctors are often approached by their

*Broadcast delivered under auspices of Florida Medical Association over Station WRUF, Gainesville, March 1, 1936.

neighbors or friends in some such manner as this: "Mrs. Poor has appendicitis and I think it is your Christian duty to treat her." If the doctor replies that he will gladly do so if the neighbor will pay her hospital bill, he will be met with the prompt statement that he "can't afford to do this." This is the attitude of most people and, strange to say, of people collectively, as represented by city, county, state and national governments.

These governments provide food, clothing, medicine in most instances, and pay the prevailing prices for them. They come to the doctors, dentists, and druggists, and ask for service at cost. Now we, as professional men, are just where we were in the beginning, and are just as willing to help with the sick poor, but we do resent this discrimination, and would like to know the reason for it. As contributors to the public funds, in the way of licenses and taxes, why should we be called upon to donate free or partly free service to these unfortunate people, and the average person connected with other services to them get full pay? The doctors have always done this service free, but should we continue? It seems that we are expected to. This notion must be one of racial consciousness handed down from its priestly beginning.

Most doctors are not mercenary but, on the other hand, are philanthropically inclined, and if left undisturbed will continue their services to the poor. There has arisen in the last few years a threat to his accustomed mode of practice and livelihood. I refer to the so-called social insurance or prepayment plan for medical services. This has been proposed in various forms, actual hiring of doctors, farming out to certain groups of doctors, who are usually political favorites, patient doctor choice with payment by some central agency with all the annoyance of a third party in such a transaction.

All of this is disturbing to the doctors and honest laymen. The most satisfactory medical service in the past has been by the fee system paid by the patient himself. It promotes efficiency in the doctors and engenders self-respect in the patients, and hence is mutually beneficial. The speaker has had considerable experience in contract practice and knows whereof he speaks. This and other prepayment and insurance plans break down the mutual trust and friendship that should always exist between doctor and patient. A few unreasonable people under any of these plans will make demands on the doctor which will be all out of proportion to the amount paid or the case demands. This will be repeated so often that after a period of time the doctor will regard most of his subscribers as malingerers, and they will consider him as being very indifferent and thus a very unpleasant situation will arise.

All plans will work out the same way except the private relationship that has always prevailed. Any other destroys the freedom of action of both parties. All other plans usually grow to such proportions that patients lose their identity and become so much grist to the mill.

Germany has had social security insurance for more than fifty years, England for twenty-five years. The plan in England is much less objectionable than that of Germany. In both countries enormous machinery has been developed for operation and thus much of the money intended for the insured is used up in the big political machine.

Florida has a law known as "The 1935 Social Welfare Act of Florida." This is in the hands of a board of five members known as the State Welfare Board and this is supreme. There are twelve district boards, accountable to no one except the State Board. You no doubt wonder what part the doctors of the state take in the operation of this and the district boards. Physicians have no representation on any of these boards. No place was given them by the law and so far as known no doctor has been appointed by the authorities. Why? Because doctors are well educated, individualists, well versed in social conditions, familiar with the needs of the sick poor, independent of action, and are average in honesty. The Florida law expires on July 1st, 1937; therefore, I think you good people had better do some thinking between now and then and if this law is to be reenacted see that all mention of professions is left out, or mention all professions and vocations that have or may have a direct interest in carrying out the law. At the present time the law is almost entirely in the hands of trained social workers. It is unwise to select any special group of people to administer any law. Some one must have detected its weakness as no money was appropriated to carry it into effect.

The leisure class of people is not an economic

problem for the doctors. The largest class of people, usually spoken of as the low income group, is a problem. These people are the very salt of the earth, are wage earners, artisan, clerks, one horse farmers, etc. They usually get along very well with ordinary sickness, but when the catastrophic illnesses occur there develops a real problem. When it is necessary to hospitalize, have nurses, in addition to doctors, they know not where to turn. Most hospitals live a hand-to-mouth existence and are not able to extend credit. Nurses by the very nature of their service must be paid as the service is performed, and the doctor, how about him? Well, he usually comes last, if there is a last, and usually there is not. He must wait for his fee. He often lives up to his income and can ill afford to wait, but he must; first, because he is supposed to, and second because he usually chooses to. This is almost a daily problem for the doctors and up to the present time no solution seems to be in sight. Under ordinary general economic conditions we can worry along very well with deferred partial payments, but during times of economic distress, when the means of livelihood are cut off and people begin to wander, the doctor is in the same predicament as his patients. Here is real tragedy for you.

As indicated, many plans have been devised, but all have the defect of more or less destroying the confidential relationship between the patient and his physician by introducing a third party into the transaction. Usually this third party is an insurer and has no interest in the case except to save the company's or lodge's funds and terminate the service as soon as possible. Often there is some joker clause in the contract that prevents any payment unless the doctors and patient prevaricate. Remember, all sickness insurance contracts are drawn mostly in the interest of the insurer. Therefore, if you are honest you had better not buy sickness insurance. Insurance is not the remedy. Thriftiness on the part of our low income group friends with systematized laying aside of money for sickness, and the payment of their own sickness bills, has, is, and will always be the most satisfactory solution of this problem.

MEDICAL LEGISLATION IN FLORIDA*

JULIUS C. DAVIS, M.D.,
Quincy.

Mr. President and Members of the Association:

Our president, Doctor Bryans, has requested me to say a few words relative to the pros and cons of medical legislation in this state.

All of the House of Representatives and one-half of the Senate are facing reelection to their places in the legislature. As many of the old members will seek reelection to the law-making body, it behooves us to consider whether we should concern ourselves with their attitude toward us in the past. Now is the opportune time to act if we are going to do anything and if not, then we should forever afterward hold our peace.

Let us wake up and remain awake if we are to combat the dangers which confront our profession. The handwriting is on the wall.

It is not necessary for me to go into detail regarding the pernicious bills which we were able to defeat during the last session of the legislature. In my report as Chairman of the Legislative Committee at Ocala last year, I promised you a detailed report as to the attitude of the membership of both houses on matters concerning the medical profession. In the July issue of the Journal of the Florida Medical Association I gave you this report.

I will, with your permission, make a few suggestions in the hope that they may be helpful in steering us nearer the goal to which our profession aspires.

I wish to reiterate my many former utterances before this Association that nothing is ever accomplished at Tallahassee *after* the session convenes. It must be done *before* the candidates are elected. There is *some* defense for the members of the legislature as they are continually annoyed from the moment of election by the pet measures of every Tom, Dick and Harry, and it is almost impossible for them to consider carefully every vital issue presented to them during the session. After a man is elected he normally has a superiority complex and has the idea that, being the choice of the people, he should not be further annoyed and that he himself knows what is best. Almost invariably if a member is approached by someone not from his own county or district he will not grant a hearing extended

*Read before the Pre-Convention Meeting of the Florida Medical Association, Jacksonville, Feb. 23, 1936.

enough to get the real facts before him, unless he has already pledged himself to someone from his county who has been familiar with the object to be discussed. Such is politics and one is waved aside just as though he were a lobbyist or a nuisance.

Gentlemen, wake up! How can we not only wake up but how can we awaken our members? I answer by saying: By asserting ourselves now and using every effort at our command to defeat those who failed to carry out their pledges to us. The worst thing we have had to undergo in the past were promises made which we had reason to believe would be carried out but which were promptly forgotten. By given word we had reason to believe we would be considered and we were unprepared for action because the given word was violated. Let us, therefore, support wholeheartedly those who supported us and whose word we found good. Let them now realize, once and for all, that we are a factor in politics and do not believe in and will not tolerate racketeering in problems of health.

Now for a few personalities made without favoritism and equally without prejudice. If we had been able to receive the same consideration and cooperation in the House of Representatives we did in the Senate, Florida would have had health laws superior to the health laws of any other state in the entire Union.

In response to my duty to this Association I went to see Senator Hodges, President of the Senate, and laid the cards, face up, on the table. I asked him for the right to have something to say about the Senate Committee of Public Health and after talking it over he gave our Association the naming of the entire Committee of Public Health as far as the Senate was concerned. The Senate Committee reported favorably on all of our bills within 30 minutes after the bills went before the Committee and passed all of them on the floor of the Senate in one afternoon on a waiver of the Rules except one of the less important which was the lien law. The House of Representatives, however, did not cooperate with us as the Senate did. In the first place the Speaker of the House, Mr. Bishop, did not give us the Committee on Public Health as he had agreed to do and Mr. Robineau, Chairman of the House Rules Committee, failed to advance our bills so they could get consideration as he had specifically agreed to do. He told me to go back and forget them and they would be taken care of at one session but instead of doing as he said he would, they never were taken up. Senator Gillis, on the other hand, Chairman of the Rules Committee of the Senate, gave us preferred place on the Calendar and the President, Senator Hodges, ordered them taken up out of their order and he disposed of them for us to our satisfaction. I found Rogers of Broward, Hubbell of Manatee, Warren of Palatka, to be our friends in the House and they deserve the support of those interested in the medical profession.

Let me urge each county to fall in line with President Bryans as he has set the pace in Escambia county by organizing a society known as "The Allied Political Health Council" composed of physicians, dentists, druggists and nurses for the purpose of discussing and taking *concerted action* on matters of common interest to these professions and the public generally on matters concerning health. In selecting candidates who will have something to do, and a very large something to do, with the progress of our profession, it should be our duty to ourselves and our profession to consider those who seek our support not only on what they say they will do for us but by what they have done and whether, by their actions, their words mean something after they have made promises.

There is another thought which seems to me proper to mention at this time. There should be another member added to the Workmen's Compensation Board who is a physician and surgeon. The value of this can be readily seen as this Board deals entirely with adjusting compensation growing out of injuries and a physician and surgeon should sit on this Board by reason of the valuable information he can give and the help he can extend in all matters of claims.

It is important we have a Governor who will pledge himself to our cause and who will consult our Association and appoint members of the State Board of Health and State Medical Examining Board who will meet with the approval of our Association and whose pledge we consider will be performed when made. Let me urge physicians to enter the political arena with the avowed purpose of protecting our interests.

SYMPOSIUM ON MEDICAL ECONOMICS

A series of broadcasts have been prepared by the Association's Committee on Public Relations which is to be given over Station WRUF, Gainesville, Sunday evening at 6:00 p. m. each week from March 1 to May 10.

Dr. J. Ralston Wells, Chairman of the Committee, and his associates, are giving a great deal of time and thought to the broadcasts. The members of the Association who are handling the broadcasts have been carefully selected by the Committee and each broadcast will be educational and of interest to all listeners.

The schedule of this symposium is as follows:

1. March 1—Introduction to Medical Economics, I—J. S. Turberville, Century.

2. March 8—Introduction to Medical Economics, II—G. C. Tillman, Gainesville.

3. March 15—Cost of Medical Education—Homer Pearson, Miami.

4. March 22—Medical Relation to Workmen's Compensation—O. O. Feaster, St. Petersburg.

5. March 29—Health Insurance—C. D. Christ, Orlando.

6. April 5—Defects in Medical Insurance—H. L. Bryans, Pensacola.

7. April 12—Contract Practice—T. H. Bates, Lake City.

8. April 19—Plans for Payment of Medical Care—W. H. Spiers, Orlando.

9. April 26—Health Insurance in England—Edward Jelks, Jacksonville.

10. May 3—Health Insurance in Various Parts of the World—T. M. Palmer, Jacksonville.

11. May 10—A Synopsis and Critical Analysis of Sick Insurance and Cost of Medical Care—J. Ralston Wells, Daytona Beach.

STATE NEWS ITEMS

Dr. Luther W. Holloway, Jacksonville, has been appointed a member of the Council of the Southern Medical Association from Florida for a regular Council term of five years, the appointment having been announced recently by the President, Dr. Fred M. Hodges of Richmond. Doctor Holloway succeeds Dr. Edward Jelks of Jacksonville, who, having served the constitutional limit, was not eligible for reappointment.

* * *

A banquet was tendered Dr. James S. McLester, president of the American Medical Association, Dr. Herbert L. Bryans, president of the Florida Medical Association, and Dr. Julius C. Davis, past-president of the State Association, on the evening of February 26 by the Dade County Medical Society. There were present at the banquet about one hundred fifty members of the Dade County Medical Society and quite a number of visiting physicians from different sections of the United States. Doctor McLester was introduced by Doctor Bryans. Talks were given by the three honor guests.

* * *

Dr. John A. Simmons of Arcadia and Mrs. Erma T. Lambert of Columbia, S. C., were married February 18, 1936, at Arcadia, Florida.

* * *

Dr. and Mrs. B. F. Woolsey of Jacksonville announce the birth of a son, Bertram Fred, Jr., at St. Luke's Hospital, February 22, 1936.

* * *

The many friends of Dr. S. H. Toy of Umatilla will regret to learn of his death on February 24, following a brief illness.

* * *

Dr. Carlos P. Lamar announces the opening of offices and clinical laboratories at 339-342 Ingraham Bldg., Miami. Practice limited to diagnosis and electro-therapy.

* * *

Dr. Edwin Preston of Miami Beach and Miss Josephine Montanus of Coral Gables were recently married.

* * *

Drs. T. Z. Cason and Louie Limbaugh of Jacksonville attended the meeting of the American College of Physicians held in Detroit early in March. En route, they spent one day at Ann Arbor.

Members of the Riverside Hospital Staff, Jacksonville, had the pleasure of hearing three guest speakers at the regular monthly staff meeting Tuesday evening, February 25. Dr. C. C. Grace of St. Augustine presented a paper on "Fungus Infections of the Ear." "Gonococcal Peritonitis of the Right Upper Quadrant" was the subject chosen by Dr. T. F. Hahn of DeLand. Dr. G. C. Tillman of Gainesville spoke on "Appendicitis in Young Men, with Reports of a Series of Cases." A number of physicians from neighboring cities were present to hear the program and enjoy the social hour afterward.

* * *

Dr. Harry Dash Johnson of Daytona Beach died February 27, 1936. Doctor Johnson was a member of the State Board of Health.

DR. MARY FREEMAN

The medical profession as well as her many friends suffered a deep loss in the death of Dr. Mary Freeman, of Perrine, on February 2, 1936. Dr. Freeman died as a result of injuries sustained in an automobile accident.

Dr. Freeman was born in Christian County, Illinois, April 27, 1868. At the age of twenty-eight, as a result of an injury and the measles, she was left an invalid for a period of twelve years from 1896 until 1908. At the age of forty she came to Dade County and regained her health. She was inspired by her appreciation of her recovery to attend medical college and educate herself to alleviate the suffering of humanity. She completed her medical course at the age of forty-four, graduating from the Medical College of South Carolina. She established her professional practice at Perrine, Florida, where she remained until her death.

Dr. Freeman was prominent in community affairs and was well known and loved for her charitable work and professional service to the poor and rich alike in the practice of her profession in her community. In many instances, patients were provided with food as well as medical attention.

Dr. Freeman was local surgeon for the Florida East Coast Railway Company, a member of the Dade County Medical Society in good standing, and an active member of regular organized medicine.

Dr. W. M. Rowlett, Secretary of the State Board of Medical Examiners, reports that at the November 11th examination held in Tampa, there were 58 applicants of which number 49 passed and were issued licenses. There were 9 failures. The Board turned down 12 applicants, 8 of the 12 being foreigners. First honors went to Dr. Carl O. Lungerhausen of Newton, Georgia, a graduate of Jefferson Medical College. He made an average of 90.7%. Second honors went to Dr. Doran T. Rue of Mattoon, Illinois, a graduate of the University of Illinois, he having made a general average of 90.6%. The successful applicants were:

Ahmann, Chester Frederic, University of Florida, Gainesville, Florida.
University of Tennessee, 1935.

Alexander, Lassar, 301 Huntington Building, Miami, Florida.
Tulane Medical School, 1931.

Andrews, Neal Leroy, 1800 43rd Street, Birmingham, Alabama.
Tulane University, 1930.

Baber, John Marion, 1819 G Street, N. W., Washington, D. C.
George Washington Medical University, 1929.

Baker, David, 222 28th Street, Miami Beach, Florida.
Barnes Medical College, 1893.

Barranco, Anthony Joseph, Polk County Hospital, Bartow, Florida.
Tulane University, 1932.

Bell, Francis Emory, St. Luke's Hospital, Jacksonville, Florida.
Emory University, 1934.

Bernstein, Henry, Wilderness, Virginia.
Georgetown University, 1932.

Boyd, Frank Harrison, Enterprise, Alabama.
Emory University, 1930.

Bull, Homer Thomas, 920 South N. Street, Lake Worth, Florida.
University of Toronto Medical School, 1927.

Cohn, Jess Victor, Phyl-Mar Apartments, Hollywood, Florida.
University of Cincinnati, 1934.

Daniels, Edgar Rudolph, 72 East End Avenue, Panama City, Florida.
Howard University, 1934.

Derrick, Clifton Jennings, University Hospital, Augusta, Georgia.
University of Georgia Medical Department, 1933.

DeWert, Charles Albert, Tampa Municipal Hospital, Tampa, Florida.
Cincinnati Medical College, 1935.

Fox, Edward Frank, 1310 N. W. 8th Court, Miami, Florida.
University of Tennessee, 1932.

Foy, William Edward, 26 Sevilla Street, St. Augustine, Florida.
Temple University of Philadelphia, 1933.

Fulmer, Herbert Clifford, 504 University Avenue, Syracuse, New York.
Syracuse University Medical College, 1916.

Hanson, Edwin Carlton, Belleview, Florida.
University of Minnesota, 1930.

Honke, Edward Max, Lewiston, Minnesota.
Creighton College of Medicine, 1932.

Jankelson, Jacob, 4867 Third Avenue, Detroit, Michigan.
Detroit College of Medicine and Surgery, 1927.

Jeffrey, James Robinson, 1008 North Cedar Street, Galesburg, Illinois.
University of Illinois College of Medicine, 1917.

Jewett, Eugene Lyon, care Dr. E. R. Shippen, Winter Park, Florida.
Harvard Medical School, 1929.
Knight, Claude Mitchell, State Hospital, Chattahoochee, Florida.
Emory University, 1934.
Lovejoy, John Fletcher, 128 Erie Avenue, Decatur, Georgia.
Duke University School of Medicine, 1932.
Lungerhausen, Carl Oscar, Newton, Georgia.
Jefferson Medical College, 1928.
Markel, Joseph, 24 North Maine Street, Manchester, Pennsylvania.
Jefferson Medical College, 1931.
McDaniel, Thomas Fincher, 1186 Clifton Road, N. E., Atlanta, Georgia.
Emory, 1934.
McGuigan, Cletus Edmund, 26 West King Street, York, Pennsylvania.
Johns Hopkins, 1922.
McKay, Roy Hayman, 833 Second National Building, Akron, Ohio.
University of Cincinnati, 1906.
McVey, Marie Cecelia, Box 1376, Miami, Florida.
Northwestern University School of Medicine, 1932.
Merritt, John Webster, Riverside Hospital, Jacksonville, Florida.
Johns Hopkins School of Medicine, 1933.
Mount, Louis Burgh, 256 State Street, Albany, New York.
Cornell University Medical College, 1905.
Nugent, James Joseph, 1053 N. W. Third Street, Miami, Florida.
St. Louis University School of Medicine, 1932.
O'Dell, John Clayton, Jr., 3401 North Calvert Street, Apt. 14, Baltimore, Md.
Johns Hopkins Medical School, 1931.
Pallister, William Thomas Hales, Englewood, Florida.
McGill University, 1897.
Perez-Lamar, Carlos A., 342 Ingraham Building, Miami, Florida.
University of Havana, 1928.
Rogers, Howard Milton, 356 18th Avenue, N. E., St. Petersburg, Florida.
University of Pittsburgh Medical School, 1935.
Rogers, William DeWitt, State Hospital, Chattahoochee, Florida.
Georgia Medical College, 1933.
Rue, Doran Therman, 203 West Orlando Avenue, Orlando, Florida.
University of Illinois College of Medicine, 1931.
Sandberg, Thowald Douglas, Lovelady, Texas.
University of Tennessee, 1926.
Skilling, Francis Curie, 457 62nd Street, Miami Beach, Florida.
Harvard Medical School, 1930.
Smith, James Alonzo, South Charleston, West Virginia.
Chicago College of Medicine and Surgery, 1915 (now Loyola).
Stritzinger, Rudolph Peter, Pensacola Hospital, Pensacola, Florida.
Tulane University, 1933.
Wallace, Albert Wicken, The Glen Springs, Watkins Glen, New York.
Western Reserve University, 1928.
Waller, Constantine Perkins, Harvey Building, West Palm Beach, Florida.
Vanderbilt University, 1915.
Watt, Edward Clements, St. Vincent's Hospital, Jacksonville, Florida.
Tulane University, 1933.
Wigdor, Meyer, 2080 Grand Avenue, Bronx, New York City.
Cornell University, 1923.
White, Sarah Parker, Florida State College for Women, Tallahassee, Florida.
New York Medical College and Hospital for Women, 1911.
Woods, Frank Moseley, Jackson Hospital, Miami, Florida.
University of Oklahoma, 1935.



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Robert Lawson Brown, Jr., son of Mr. and Mrs. R. Lawson Brown of Macon, Ga., died Jan. 24 following a double mastoid operation. He was the 3½-year-old grandson of Dr. and Mrs. W. H. Grace of Ft. Myers.

* * *

Dr. Sam Roberts of Miami announces the removal of his office to 348 Ingraham Building.

* * *

The Sixty-third Annual Meeting of the Florida Medical Association will be held on board the S. S. "Florida". This spacious boat will leave Miami Monday morning, docking at Havana, Cuba, Tuesday noon. It will dock at Miami, on its return trip, Wednesday noon.

The preliminary program will be shown in next month's Journal; scientific program sessions, general sessions and meetings of House of Delegates will be held on board ship.

Elaborate arrangements for sight-seeing trips in Havana Tuesday afternoon, as well as golfing, have been made for the entertainment of Association members and their guests. This is an unusual opportunity for a very pleasant trip. Members who contemplate attendance at this meeting should make their reservations with the P. & O. Steamship Company, Jacksonville, without delay.

COMPONENT COUNTY SOCIETIES

BAY COUNTY MEDICAL SOCIETY

Tuesday, January 7, 1936, Bay County Medical Society held its first monthly meeting of the new year. The following officers were re-elected for the year: President, Dr. W. C. Roberts; Vice-President, Dr. J. M. Nixon; Secretary-Treasurer, Dr. Allen H. Miller. Dr. D. M. Adams was elected as delegate to the State Association; Dr. W. C. Roberts as alternate delegate.

Tuesday, February 4, 1936, the society had its regular monthly meeting with the following program given: "Pneumothorax and Pulmonary Tuberculosis" (with x-rays of cases), Dr. Sidney Latiolais of Dothan, Ala. "Cancer of the Cervix", with lantern slides to illustrate, was presented by Dr. John T. Ellis, Dothan, Ala.

These papers were very educational and were greatly enjoyed.

DE SOTO-HARDEE-HIGHLANDS COUNTY MEDICAL SOCIETY

The DeSoto-Hardee-Highlands Medical Society met in Arcadia, Jan. 14th, 8 p. m., at the Cavas Restaurant, with the following members

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present: Drs. Weems, McSwain, Bevis, Poucher, Kayton, McKnight, Martin, Brewster, Simmons, Kirkpatrick and Chandler. Visitors, Drs. Vinson and Brown, both of Tampa.

Under new business, the report of the Board of Censors on the application of Dr. H. E. Boorom, of Sebring, was asked for and was reported on favorably, and he was unanimously elected a member of the Society.

The matter of the next State Medical Meeting on cruise from Miami was brought up and discussed. Each member desiring to make this trip was advised to send in his reservation with fee of ten dollars ($10.00) at once.

Dr. Vinson, of Tampa, gave a most interesting discussion on "The Treatment of Syphilis," which was enjoyed and discussed by all present.

Dr. H. O. Brown, of Tampa, read a paper on "The Present Status of Radiation Therapy."

There being no further business, the society adjourned to meet in Avon Park in February.

The regular monthly meeting of the DeSoto-Hardee-Highlands County Medical Society was held in Avon Park, Feb. 11, 8 p. m., at the Jacaranda Hotel with the following members present: Drs. McKnight, Poucher, Weems, Chandler, Brewster, Boorom, Martin, and Touchton. Visitors: Drs. Boulware and Bosworth, both of Lakeland, and Dr. Slessor, of Scotland.

Dr. J. M. Bosworth, of Lakeland, read a paper on "The Use of the McBurney Incision," which was discussed by Drs. Boorom, Martin, Boulware, Slessor and Weems.

Dr. Boorom, of Sebring, read a paper on "Narcolepsy," which was discussed by Drs. Weems, McKnight, Boulware, and Brewster.

There being no further business Society adjourned to meet in Sebring in March.

DUVAL COUNTY MEDICAL SOCIETY

The Duval County Medical Society met in regular session on the evening of March 3. The scientific program consisted of a paper by Dr. Ferdinand Richards on "Sterility." The discussion of this paper was opened by Drs. Thomas Field and Lucien Dyrenforth.

The following resolutions on the death of Dr. Herrman Harris were adopted by the Society:

"Whereas Divine Providence has seen fit to remove from our midst our beloved colleague and friend, Dr. Herrman Hirsch Harris, at the zenith of his most useful period of life,

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"Be it resolved, That in the passing of Doctor Harris no ordinary loss has been sustained. Gifted intellectually as he was to the highest degree, imbued with an overwhelming love of humanity, his death will prove a blow not only to his family, his friends and his profession, but to mankind in general for whom he so faithfully and unselfishly labored.

"Be it further resolved, That Doctor Harris' presence will be long and sorely missed by the members of the Duval County Medical Society who found in him an ever-willing advisor and true friend, by St. Luke's Hospital which he served for nine years in the capacity of Chief of Staff, by St. Vincent's Hospital and by the Duval County Hospital to which organizations he gave unstintingly of his time and talent, and also by his host of friends and patients.

"Be it further resolved, That a copy of these Resolutions be spread upon the minutes of the Duval County Medical Society; that a copy be sent to his family; and that the same be published in the Journal of the Florida Medical Association.

Shaler Richardson, Chairman;
William W. Kirk,
Robert B. McIver,
Ben Manhoff,
Committee."

MARION COUNTY MEDICAL SOCIETY

THE MARION COUNTY MEDICAL SOCIETY IS THE SECOND SOCIETY TO REPORT 100% OF DUES FOR 1936. THIS SOCIETY HAS A MEMBERSHIP OF TWENTY-ONE ACTIVE AND ONE HONORARY MEMBER. CONGRATULATIONS.

ORANGE COUNTY MEDICAL SOCIETY

At the annual meeting of the Orange County Medical Society, the following officers were elected:

President—William E. Sinclair, Orlando.
Vice-President—F. H. Harms, Orlando.
Secretary—J. A. Pines, Orlando.
Treasurer—Spencer A. Folsom, Orlando.

The following resolutions have been adopted by the Orange County Medical Society in the death of Dr. Haynes Brinson of Kissimmee:

"On January 7th, 1936, our fellow physician, Dr. Haynes Brinson, was called to the great beyond, following a brief illness.

"Born in Valdosta, Georgia, July 21st, 1881, he



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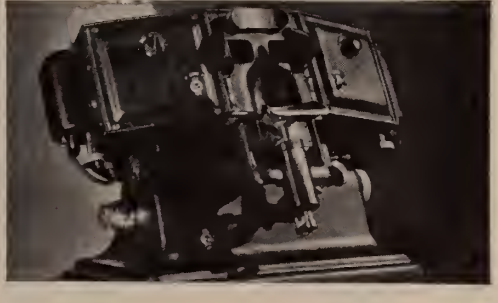
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spent his early life there. He graduated from Emory University Medical College in 1912.

"He began the practice of medicine in Cecil, Georgia, in 1913 and remained there until 1921 when he moved to Kissimmee, Florida, where he practiced until his death.

"Dr. Brinson was at one time a member of the Kissimmee City Commission and was County Physician for several years, serving in that capacity up to the time of his death.

"He was a Baptist, being a Deacon of his church, and was also a Mason and Shriner.

"He is survived by his wife, Mrs. Bid Brinson, and a son, Edward, of Kissimmee, and several brothers and sisters living in Georgia.

"Dr. Brinson was conscientious, quiet and unassuming. He inspired confidence, loyalty, and devoted friendship of those with whom he was in contact.

"Whereas, we, the members of the Orange County Medical Society, feel deeply the loss of our fellow member, Dr. Haynes Brinson;

"THEREFORE BE IT RESOLVED, That the members of this society express their sorrow in his passing, that a copy of this resolution be spread upon the minutes of the society as a reminder to us, and that copies be sent to his bereaved family, and published in the Journal of the Florida Medical Association.

W. H. SPIERS, Chairman;
T. M. RIVERS,
FRANK GRAY,
Committee."

VOLUSIA COUNTY MEDICAL SOCIETY

The Volusia County Medical Society is this year headed by the following officers:

President—H. W. Henry, New Smyrna.
Vice-Pres.—J. Ralston Wells, Daytona Beach.
Sec'y-Treas.—W. C. Chowning, New Smyrna.

WALTON-OKALOOSA COUNTY MEDICAL SOCIETY

TO THE WALTON-OKALOOSA COUNTY MEDICAL SOCIETY GOES THE HONOR OF BEING THE FIRST OF THE COMPONENT SOCIETIES TO REPORT 100% OF MEMBERSHIP DUES FOR 1936. THE OFFICERS OF THIS SOCIETY ARE:

President—R. B. SPIRES, DEFUNIAK SPRINGS.
Vice-President—C. W. McDONALD, DEFUNIAK SPRINGS.
Sec'y-Treas.—A. G. WILLIAMS, LAKEWOOD.

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Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245★
Laryngoscope 1935 XLV, 149-154★
N. Y. State Jour. Med. 1935, 35—No. 11,590★



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Jacksonville, Florida

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DEAR AUXILIARY MEMBERS:

It is just a few more weeks until we meet again at our annual State Convention. This time we will meet aboard the Steamship "Florida," and I trust that many of you are planning to attend. The business meeting will be held on Tuesday, April 28th, at 9:30 a. m. All doctors' wives and guests are invited to attend whether members of the Auxiliary or not.

We are looking forward with a great deal of pleasure to having Mrs. Rogers N. Herbert, president of the Woman's Auxiliary to the American Medical Association as our guest at this meeting. I am sure that each of you will enjoy meeting Mrs. Herbert and derive from her inspiration and help for our future Auxiliary work.

The committee in charge of this cruise has assured us a good time and I am hoping to see a large delegation ready to embark from Miami on April 27th.

Cordially yours,
(MRS. E. W.) CLARA G. VEAL,
President.

1935 - 1936

RECOMMENDATION FROM ORGANIZATION COMMITTEE OF WOMAN'S AUXILIARY TO AMERICAN MEDICAL ASSOCIATION.

Mrs. J. Bonar White, Chairman.

1. That each Auxiliary be sent two copies, one for State President, one for Chairman of Organization, of pamphlet, "Membership in an Auxiliary," to assist in membership and attendance in county auxiliaries.

2. That State Chairmen of Organization suggest these recommendations to county Auxiliaries.

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1. The county committee on organization have three divisions: One division make a list of former officers and chairmen in that Auxiliary, compare it with paid membership of 1934-1935 and invite those delinquent, to re-join.
   Second division make list of all who have ever been members, exclusive of above, and seek the membership of those who were delinquent last yaar.
   Third division invite all who have never been members and those recently eligible.
2. That each county Auxiliary have a telephone committee as large as the number of committees in the Auxiliary.
3. That each member of the telephone committee be responsible for one standing committee of her Auxiliary, and that she remind the chairman and members of that committee, of each meeting, as to date, place, time, program, at least five days before the meeting, or as local needs require.

This means that the President of the County Auxiliary reminds the Chairman of the Telephone Committee, and Chairman of Committee calls her Committee, and Committee calls its assigned Chairmen.

These are made with the idea that while many presidents will think of such plans, work begins more promptly if an outline of approved suggestions have been prepared, which are logical, definite, workable.

Membership is not mandatory, coaxing not in order.

Please give each County Chairman of Organization the necessary information about her duties and the approach to eligible women.

Our sincerest good wishes for success in your state.

Orange County Medical Auxiliary

The January meeting of the Orange County Medical Auxiliary was held at Colonial Cottage, with the president, Mrs. L. C. Ingram, presiding.

Interesting reports were heard from all standing committees. Mrs. C. D. Christ introduced the guest speaker, Mrs. Gritz Achenbach, who gave a most interesting talk on social conditions and social service work in Germany. Mrs. Achenbach has been a resident of Orlando for several years but is a native of Germany and keeps in close touch with conditions there. Mrs. Christ first knew Mrs. Achenbach in Girl Scout work.

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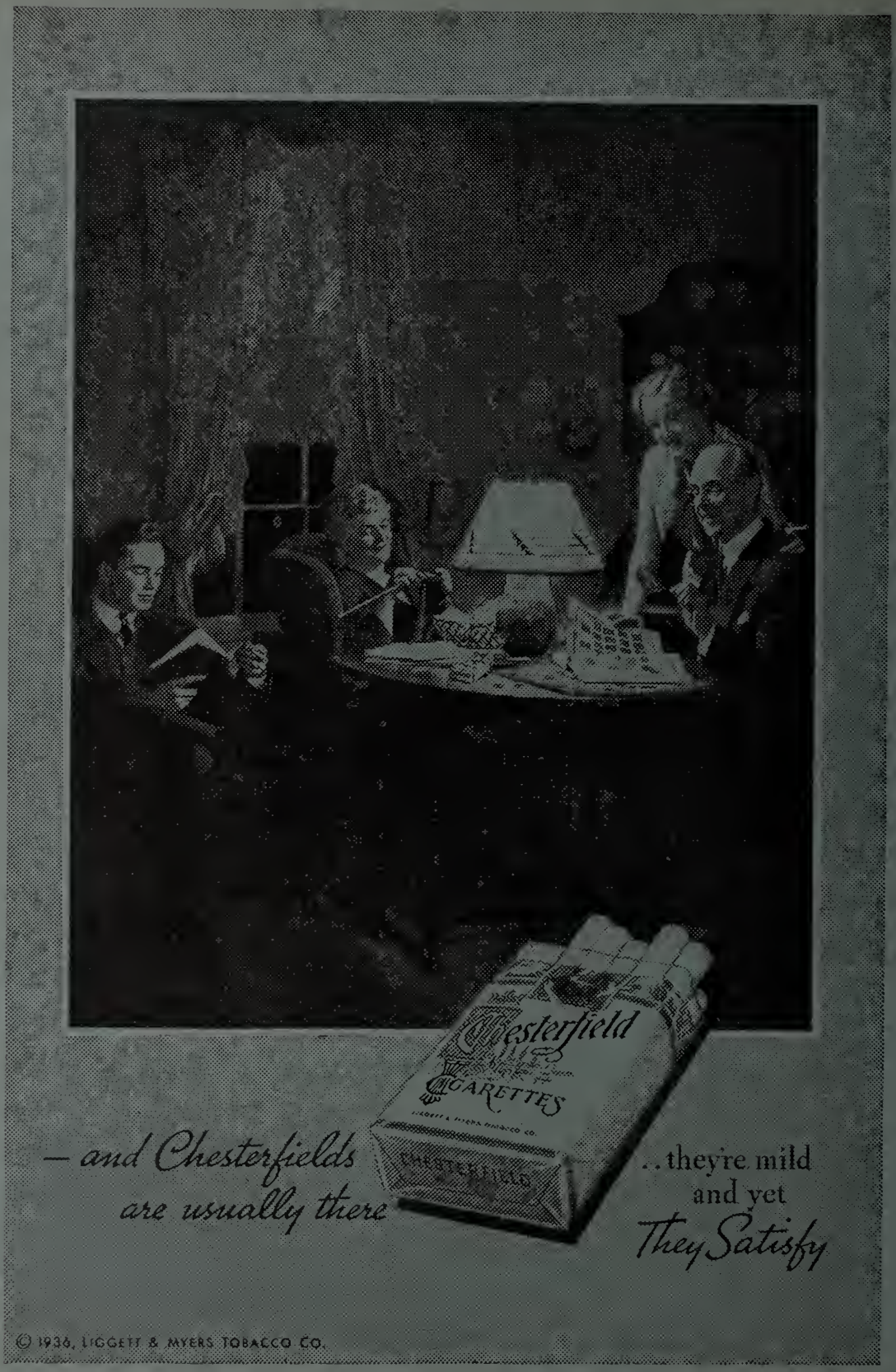
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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	J. E. Maines, Jr., M.D., 331½ W. University Ave., Gainesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Tuesday 12:00 noon	White House, Gainesville		
Bay	W. C. Roberts, M.D., Panama City	Allen H. Miller, M.D., Millville			1	10%
Brevard	I. F. Bean, M.D., Melhourne	Boh Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies	3	33%
Broward	Elliott M. Hendricks, M.D., 314 Sweet Building, Fort Lauderdale	R. E. Blount, M.D., 360 S. E. 26th Ave., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale		
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	9	90%
Dade	John E. Hall, M.D., Box 2722, Miami	M. E. Threlkeld, M.D., Congress Bldg., Miami	1st Friday 8:30 P.M.	Club Rooms Huntington Bldg., Miami	115	52%
DeSoto-Hardee-Highlands	C. H. Kirkpatrick, M.D., P.O. Box 454 Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies	2	10%
Duval	W. M. Shaw, M.D., St. James Bldg., Jacksonville	H. W. Porter, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	81	55%
Escambia	A. M. Ames, M.D. Blount Bldg. Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola	15	37%
Hillshoro	William C. Blake, M.D., 412 Citizens Bank Bldg. Tampa	James S. Grahle, M.D., 822 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa		
Jackson	C. D. Whitaker, M.D., Dekle Bldg. Marianna	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna	7	54%
Lake	R. H. Williams, M.D., Eustis	W. L. Ashton, M.D., Umatilla	1st Thursday 12:30 PM.	Eustis	11	73%
Lee	William H. Grace, M.D., 15 Earnhardt Bldg., Fort Myers	H. Quillian Jones, M.D. 18-20 Leon Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers	8	80%
Leon-Gadsden-Liherty-Wakulla-Jefferson	R. F. Godard, M.D., Key Building, Quincy	B. A. Wilkinson, M.D., Telephone Bldg., Tallahassee	Quarterly 3:00 P.M.	Varies	10	26%
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison			1	33%
Manatee	S. G. Hollingsworth, M. D. 451 12th, St. Bradenton	M. M. Harrison, M. D. Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Club Bradenton	11	85%
Marion	J. N. Moore, M.D., 210-12 Professional Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala	21	100%
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies		
Orange	William E. Sinclair, M. D. Clinic Bldg. Orlando	J. A. Pines, M.D., 106-10 E. Central Ave., Orlando	3rd Wednesday 8:30 P.M.	Varies		
Palm Beach	L. McK. Rozier, M.D., 411 Comeau Bldg., West Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach	32	59%
Pasco-Hernando-Citrus	R. D. Sistrunk, M.D., Dade City	John J. Bourke, M.D., Dade City	2nd Thursday 7:00 P.M.	Varies		
Pinellas	F. E. Kauffman, M.D., Coachman Bldg., Clearwater	W. C. McConnell,, M. D. 1005 Equitahle Bldg. St. Petershurg	1st Friday 8:00 P.M.	Assemhly Room, 5th Floor, P. & L. Bldg., St. Petershurg	65	78%
Polk	R. L. Hughes, M.D., 225 E. Main St., Bartow	J. R. Boulware, Jr., M.D., P. O. Box 367, Lakeland	2nd Wednesday in Feh., April, June, Aug., Oct., Dec. 1:00 P.M.	Lakeland		
Putnam	Allen P. Gurganeous, M. D. Palatka	A. E. Drexel, M.D., Palatka	2nd Thursday 7:00 P.M.	James Hotel, Palatka	8	100%
St. Johns	Herhert E. White, M.D., 401 First Natl. Bank Bldg St. Augustine	R. D. Harris, M.D., St. Augustine	3rd Tuesday 8:30 P.M.	Varies	9	90%
St. Lucie-Okeechohee-Indian River-Martin	J. D. Parker, M.D., P. O. Box 942, Stuart	E. B. Hardee, M.D., Vero Beach	3rd Thursday 8:00 P.M.	Varies		
Sarasota	C. B. Wilson, M.D., 1st B. & Tr. Bldg., Sarasota	J. E. Harris, M.D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P.M.	Varies		
Seminole	J. T. Denton, M.D., Meisch Bldg. Sanford	Douglass G. Scott, M. D. Box 489 Sanford	2nd Monday 7:00 P.M.	City Hospital Sanford	12	100%
Sumter	A. B. Alhritton, M.D., Wildwood	W. E. Mitchell, M.D., Box 237 Coleman	2nd Tuesday	Varies		
Taylor	W. J. Baker, M.D., Foley	C. A. O'Quinn, M.D., Perry	Last Friday 8:00 P.M.	Dixie-Taylor Hotel, Perry		
Volusia	H. W. Henry, M.D., 205 State Bank Bldg., New Smyrna	W. C. Chowning, M. D. 111 Palmetto St. New Smyrna	2nd Tuesday 7:30 P.M.	Varies	21	53%
Walton-Okaloosa	R. B. Spires, M.D., DeFuniak Springs	A. G. Williams, M.D., Lakewood	3rd Thursday 8:00 P.M.	Varies	6	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



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Florida Medical Association, S.S. Florida, April 27, 28, 29, 1936.
American Medical Association, Kansas City, Mo., May 11-15, 1936.
Southern Medical Association, Baltimore, Md., November 17-20, 1936.

Entered as second-class matter under Act of Congress of March 3, 1879, at the Postoffice at Jacksonville, Florida, October 23, 1924

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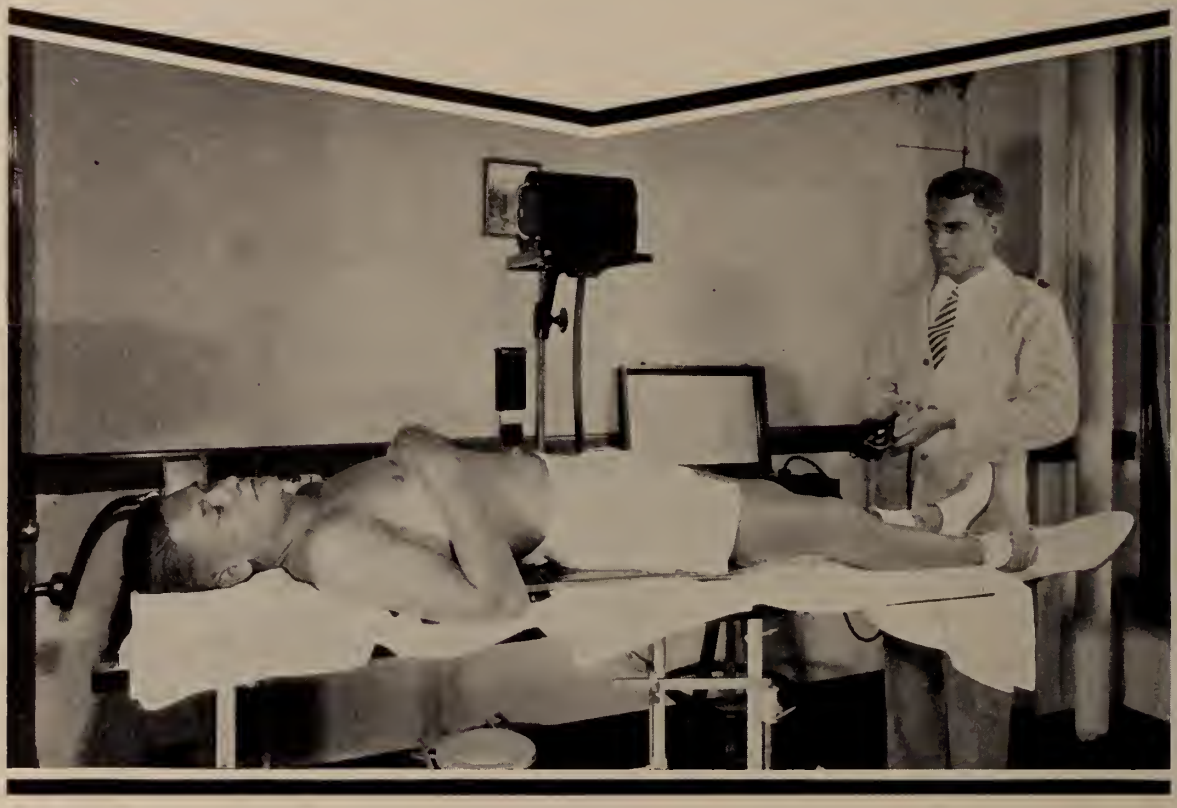
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CANNED FOODS AND THE PUBLIC HEALTH

III. Chemical Preservatives

• Some of our readers have inquired as to whether or not chemical preservatives are used in commercially canned foods. In certain instances, this question was inspired by the fact that "canning compounds" were formerly sold for use in home canning and preserving operations. Such compounds, however, are rarely used by the housewife of today, and never by commercial canners.

We wish to state here that *no preservatives are used in commercially canned foods.*

Spoilage of food is principally caused by the growth and multiplication in food of microorganisms such as yeasts, molds, or certain types of bacteria. These microorganisms depend upon the food they inhabit for their nutrition and their life processes produce changes in the chemical or physical characteristics of food, or both. These changes lead us to state that the food has "spoiled".

Like other living organisms, these spoilage microorganisms can grow and multiply in a food only as long as conditions remain favorable for their existence. If any environmental factor, such as temperature, moisture or acidity, becomes unfavorable, these spoilage organisms are destroyed, or their development is inhibited.

All methods of food preservation have a common underlying principle; they all alter some factor or factors in the food environment so as to render conditions unfavorable for the growth or development of spoilage organisms in the food.

Thus, foods may be preserved by freezing or refrigeration, which serves to lower the temperature below that optimum for growth of certain spoilage organisms; dried foods keep because the moisture content has been reduced to an unfavorably low level; certain fermented foods keep because of the development of high acidity. All of these methods produce changes in the environment in which the food spoilage organisms must live.

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The hermetic seal insures protection against future infection of the food by such organisms.

Thus, commercial canning is a method of food preservation which has for its basis the thermal destruction of spoilage organisms; no chemical preservatives are needed to insure preservation of the foods, and, consequently, none are used.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

(1) The Microbiology of Foods, F. W. Tanner, Twin City Pub. Co., Champaign, Ill., 1932

This is the eleventh in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Committee on Foods of the American Medical Association.



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The formula in abrupt weaning prepared for the entire day consists of 24 ounces milk, 8 ounces water, 3 tablespoons Karo, divided into 4 feedings, 8

Feeding	*1st Week*	*2nd Week*	*3rd Week*	*4th Week*
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10:00 A.M.	Breast	Breast	Bottle	Bottle
2:00 P.M.	Breast	Bottle	Bottle	Bottle
6:00 P.M.	Bottle	Bottle	Bottle	Bottle

ounces each, at 4 hour intervals. The formula can be concentrated once the baby is adjusted to the bottle feeding.

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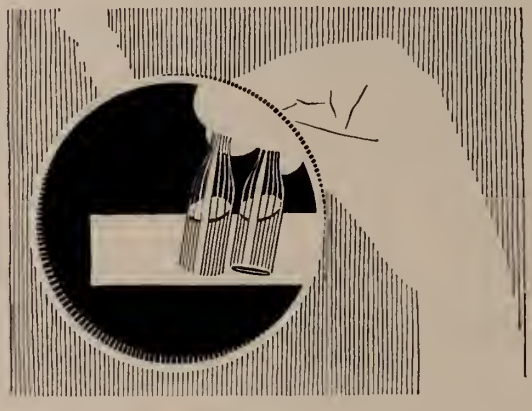
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IMPORTANT CONSIDERATIONS IN THE HANDLING OF DIABETIC PATIENTS*

T. Z. Cason, M.D.,
Jacksonville.

Diabetes as a recognized disease entity appears to be age-old. For twenty centuries at least it has been studied patiently and by an enormous number of investigators. About 50 A. D. Celsus† not only defined this disease but advised treatment and a diet. In the same century Aretaeus described it as "melting down the flesh and bones into urine" and named it diabetes which, roughly translated from the Greek, means "to run through a siphon." Galen (131-201 A. D.) called it "urinous diarrhea" and a contemporary Chinese physician (200 A. D.) described it as the "disease of thirst." Three therapeutic measures—bleeding, emetics, and narcotics—were introduced about 550 A. D. by Aetius and were in use for a long period.

In India in the sixth century B. C. Susruta first mentioned the sweetness of diabetic urine, calling it "honey urine," but general recognition of this cardinal symptom did not come for two thousand years. Although its sweetish quality had already been noted many times, an Englishman named Willis (1621-1675) has been credited with the discovery that it had the taste of honey or sugar. He did not, however, think that sugar was actually present for he believed diabetes was a disease of the blood, advancing such probable causes as worry, poor hygiene, nervous diseases, and even the acid reaction of fermented wine. In order to "thicken the blood and supply salts" he suggested a limited intake of food, thus introducing the first undernutrition diet. His use of lime water for diabetics was the first step in drug therapy. Only after Willis advanced the idea that diabetes was a disease of the blood and that diabetic urine had a sweetish quality, did the importance of this salient feature come to be recognized in diagnosis, making possible differentiation from polyuria or other symptoms and introducing the subsequent dietary regime.

A full century later Dobson (1776) completed Willis' study by showing that sugar was present in the urine of diabetics and also that their blood serum had a sweet taste, but he introduced the error that the diabetic must eat in excess to make up for the loss of nutritive material. Twelve years later, in 1788, Cawley made the first diagnosis of diabetes by the demonstration of sugar alone, and also demonstrated a pancreatic lesion in a diabetic necropsy. William Cullen added mellitus to the name of the disease and John Brown added the idea of exercise as a form of treatment.

Of all the men who advanced treatments for diabetes Naunyn, until 1914, doubtless had a larger following than any other. He introduced the word acidosis and judged the severity of cases by the degree of acidosis present. His school held that diabetes was an inherited tendency, and that it was a functional disorder. It was in 1796 that Rollo, an English army surgeon, treated his first diabetic in a radically original way by ordering a strict diet composed principally of rancid meat and intended to prevent the formation of sugar in the stomach. From that time down to the Naunyn era absence or presence of carbohydrates had been the basis of nearly every cure for diabetes. Naunyn, however, held the theory that it was more likely undernutrition than any specific article of diet that caused the improved condition among diabetics.

The "Allen era" followed, extending from 1914 until 1922. A case of Joslin's in which the diabetes improved as the patient failed in strength from tuberculosis stimulated the experiment from which Allen found that no particular type of food was good or bad for a diabetic but rather that he must always be limited in amount of diet. He evolved the Allen fasting treatment, the general adoption of which was largely due to Joslin. The theory underlying this treatment was that diabetes is not only a disorder of carbohydrates

*Read before the Florida East Coast Medical Association, St. Augustine, Nov. 1, 2, 1935.

†The historical account of diabetes is based on "The Historical Trend of Diabetes," by Eleanor J. McDonald, which appeared in *The Commonwealth,* Quarterly Bulletin of the Massachusetts Department of Public Health, Vol. 21, No. 2, April-May-June, 1934.

assimilation, but of the whole metabolism generally.

When von Brunner, a contemporary of Willis, in 1683 depancreatized a dog and then observed the symptoms typical of diabetes mellitus, he took the first step toward the discovery of insulin. From that period late in the seventeenth century, progress in diabetes developed along two lines, diet experimentation and an inevitable trend toward the discovery of insulin through animal experimentation and increasing accuracy in the laboratory research. It was, however, more than a century before the actual relationship between diabetes and the pancreas was realized. Innumerable scientists were seeking the cause of the disease but it was not until 1889 that it was establish when Minkowski and von Mering extirpated the phole pancreas of a dog at Naunyn's famous Strassburg school, finding the pancreatic gland to be the seat of diabetic disease.

After Langerhans, in 1869, discovered the division of the pancreas, histology kept pace with other advance. Various demonstrations proved that the islands of Langerhans are ductless glands, secreting an anti-diabetic hormone for which Sir Sharpey Schafer, in 1916, proposed the name "insulin." There followed numerous attempts to find through chemical methods this substance, as yet only an hypothetical secretion. Using the pancreas of an unborn calf, Banting and Best, in 1922, finally extracted the product which relieves all symptoms of diabetes, and its commercialization followed. In this "Banting era" it is not yet possible, however, to say whether the islands of Langerhans can be replaced sufficiently to function as normal glands. It is nevertheless true that even in most severe cases treatment with insulin has brought patients back to normal, and insulin has been lessened and even stopped in cases where the percentage of blood sugar is controlled by diet.

Whether fallacious or not, statistics show that diabetes is on the increase and that death from diabetes has not decreased. Moreover, the life expectancy of the diabetic has not materially increased except in the young. Numerous contributions on diabetes by recognized authorities have for the last few months been presenting this information to us. An unqualified acceptance of the conclusions that must be drawn from these statistics would appear to be a serious indictment of the medical profession and more particularly of those who have special diabetic clinics or see a relatively large number of diabetics. Either this or the much-heralded and widely distributed statements of our progress in handling diabetes are misleading in intent or in fact. As incongruous as it may appear, I am convinced that neither the statistics nor the much-publicized progress is fallacious. Why then the inconsistencies and where the difficulty? In an attempt to answer these questions, I began an analysis of the handling of my private patients and of those attending the diabetic clinic at the Duval County Hospital in Jacksonville over a period covering nine years.

The scope of this paper does not warrant a discussion of the etiology or pathology of diabetes, but certain details of the treatment will be considered. Suffice it to say that much information is constantly being added to the accumulated knowledge of the cause of this disease and it is within the realm of possibility that many of our preconceived ideas may have to be markedly changed. For instance, heredity, which was until recently not presumed to be a cause, is now generally admitted to be a factor. The weight of opinion is that genetically diabetes is of the recessive gene type according to the Mendelian hypothesis. Some investigators, however, disagree with this theory and go so far as to advance the idea that it is probably of the dominant type. The pathology of the disease is not particularly pertinent to this discussion except in its relation to the sequelae. The relation between diabetes mellitus and arteriosclerosis and the influence of diabetes mellitus as a causative agent in producing an early hardening of the arteries are fairly well established. Both Rabinowitch and Joslin have demonstrated that the high fat, high caloric diet produces a high cholesterol. This is apparently a causative factor in producing an early arteriosclerosis in the diabetic. Conversely, a high carbohydrate, low fat, low caloric diet causes in turn a low cholesterol. If this theory is correct, arteriosclerosis in the diabetic may be abolished, thereby materially extending the span of life for the diabetic. The general ignorance of and indifference to diabetes on the part of both the doctors and the lay public in the pre-insulin era would lead one to conclude that many individuals had a relatively high blood sugar with sugar in the urine without any untoward symptoms. Being ignorant of their condition, naturally these patients made no changes in their diet; hence, there was no dietary imbalance. Many cases, therefore, doubtless went undiagnosed, did not develop early arteriosclе-

rosis, and died of a wholly unrelated disease without diabetes ever having been suspected.

Before discussing the treatment, I wish to present to you certain observations of my own that I may thereby induce those of you having little or no knowledge of the handling of diabetics either to acquire sufficient knowledge to handle such patients properly or to refer them to individuals fully capable. Also, I would urge upon you the value of understanding the psychology of the diabetic, as related both in a broad way to the disease itself and in a special way to the individual patient, so that his problem becomes an intensely personal one in which sufficient pressure can be brought to bear to secure from him absolute obedience and cooperation. Further, I wish to demonstrate to you that when the diabetic is properly handled and required to live up to the instructions given him, the sequelae are materially reduced and certain common complications, such as gangrene, can be almost entirely eliminated.

The diabetic clinic at the Duval County Hospital has been under my supervision since 1926. Previous to the establishment of this clinic all diabetic patients were referred to the in-patient department for handling. Now only the extremely severe cases or those with serious complications are hospitalized. While it takes a somewhat longer time to get patients in the out-patient department on the proper balance, so far no serious complications have arisen from this method of handling them.

At present, there are under my observation at this county institution 65 cases in the out-patient department. These are divided as follows: 61% white and 39% colored; 19% white males and 42% white females; 6% colored males and 33% colored females. Interestingly enough, these statistics are racially almost identically in proportion to the white and colored populations of the city of Jacksonville. The average daily attendance of the special diabetic clinic has for the nine-year period been eleven patients per clinic day. The clinic is held one afternoon each week.

A triple check is kept on each patient who comes to the clinic at the County Hospital. On his history note is made of what is done, his condition, and when he is to return. A calendar or so-called "tickler" system is also kept and the day he is to return is recorded there. Notice is written across each insulin prescription that it is no longer good after the date the patient is to return. If the patient fails to return at the specified time, nothing is done about it but his name is set up until the next week. If he fails to return then, the social service department is notified and a worker investigates. The result of the investigation is recorded on the patient's history and the information comes to me.

One of the results of handling diabetic patients in the manner described is that only two patients during the nine years have developed diabetic gangrene, while in the hospital wards since 1926 there have been 151 diabetics admitted, 16 of whom had diabetic gangrene and 33 of whom died. That some of these cases of diabetic gangrene were preventable is illustrated by a recent happening. While making ward rounds since this paper has been in the process of preparation, I investigated a commotion in the hall to find that a patient had just died as the result of an operation for diabetic gangrene. The records in the case revealed that this man had been seen first in the out-patient department six months before. Both then and again later when he came a second time, his urine showed 4-plus sugar. Neither time was he referred to the special diabetic clinic. The third time he came in as an emergency case and was operated upon. Like him, none of the other 15 patients who developed diabetic gangrene had ever been referred to the diabetic clinic.

Eighteen of the patients in the special diabetic clinic, eight white and ten colored, have died during the nine-year period. As the average age of the group is 45.2 years, some deaths were therefore inevitable; however, a number were preventable. For instance, a negro woman had a proven gall-bladder disease but refused operation. She had considerable digestive distress and a marked fluctuation of her blood sugar. She finally came to the hospital in coma and died. Another, a girl of 19, was sent in for a tonsillectomy. Her records followed her, yet she was allowed to die in diabetic coma following the tonsil operation. This occurrence was inexcusable. In cooperation with surgeons in my private practice, I have not yet lost a single diabetic as a result of a surgical operation. In the clinic we have not handled any children under ten years of age, but up to the present, except for the young woman mentioned, we have not lost one of our younger patients through death.

Singularly enough, of the 65 patients now in the clinic only one white and three colored had a positive Kahn reaction. A test for syphilis is routine. This small proportion is far below the

average for the patients attending the out-patient department of the hospital.

That the diabetic develops a psychology peculiarly his own is well recognized. A characteristic psychology is perhaps more evident in diabetes than in most diseases. We all know the patient who slips downstairs in the middle of the night to steal from herself the cake baked for the family during the day. Familiar, too, among our patients is the man who dodges into the corner drug store to buy a chocolate bar, carefully hides it in his pocket, then goes around the corner or up the nearest alley to eat it. Or perhaps he carries all the time in his pocket the forbidden peanuts. We observe how the slice of bread increases and other portions vary from the prescribed diet although the patients know they are disobeying and that these deviations are detrimental to them. Intelligence is not a factor in the psychology of this group. To insure the successful handling of diabetics, recognition of the psychology peculiar to these patients should be correlated with a careful study of each individual, his environment, and his temptations.

For practical purposes I have come to think of the diabetics as being classified in three types: the youthful diabetic, that is, the child and the young adult; the arteriosclerotic diabetic; and the obese diabetic. This classification has helped materially not only in the matter of treatment but in every detail of the handling of the diabetic patient. We will grant that the etiology of the first type is not as yet known. Much more, however, is known and understood of the pathology of the other two types. In the case of the child or young, growing adult, the problem is a matter of, first, a properly balanced as well as adequate diet; and second, the amount of insulin necessary to supply the needs of the individual on this diet. It is imperative that the child or developing adult have a high carbohydrate diet, which enables him to have a relatively low fat diet, so desirable in preventing early arteriosclerosis. The arteriosclerotic patient, however, is at the opposite end of life from the child. He is not growing; his dietary demands are fewer; his arteriosclerosis and his kidney condition must be considered. He should be placed on a maintenance diet with only sufficient calories to keep his body weight slightly below the accepted normal. He can then be more easily stabilized as to both his caloric intake and his insulin. These cases generally will require insulin. The obese diabetic is the easiest of all to treat if the patient will cooperate properly. He should be placed on a relatively high carbohydrate maintenance diet. Put it another way: he should be treated as an obese patient and reduced. If insulin is necessary at first, and it usually is, this should be supplied, but this type of patient should report every thirty days for weight, urine, and blood sugar check-ups. Usually these patients are from 50 to 75 pounds overweight. By the time they have reduced 25 to 30 pounds, insulin is generally unnecessary. I have seen a number of the patients run blood sugars below the average normal before they reached their normal weight level.

Certain general rules should be known which are applicable to the handling of the diabetic, but as soon as experience is gained, these should be forgotten. In no other class of patients is it so true that each patient is a law unto himself. All too frequently patients come to the clinic with well advanced cases of diabetes, previously diagnosed, yet they have no knowledge of their dietary requirements and less of their insulin requirements. This deplorable state of affairs usually exists because the patient's physician has simply said, "Go home, cut out sweets, and take 1 cc. of insulin twice daily,"—or something similar. The only explanation one can make of such handling of the diabetic patient is that the doctor is either too ignorant or too indifferent to outline the proper treatment. Not for one moment would he treat his tuberculosis case, his typhoid or diphtheria patient in such a careless manner. Yet diabetes is potentially as serious as any of these. As a rule I have blood sugars taken on non-insulin diabetics fasting. Those patients taking insulin we check two hours after breakfast. Before one is able to understand the peculiarities of the individual patient, it is sometimes necessary to take several blood sugars at various times during the day. I think it is seldom necessary except in young children to give insulin more than twice daily. The diabetic must be taught to weigh or measure his own food and should be required to give his own insulin.

There are two schools of teaching as to the treatment of the diabetic coma: one which gives glucose and then additional insulin to balance it; and the other which does not give glucose but gives sufficient insulin to relieve the coma. Of much more importance than which school of thought you follow is the necessity of watching

most carefully and constantly your coma case, treating that patient from hour to hour as his condition demands. No rule can be followed absolutely and orders can not be issued long ahead.

DISCUSSION

No superior knowledge of the treatment of diabetes is claimed. Diabetic gangrene even in the far South is fairly common as evidenced in Jacksonville by the admissions to the County Hospital. Because of the method used in conducting the special diabetic clinic, diabetic gangrene has developed in only two cases while under my observation there. Complications as a result of diabetes have been very few. Deaths in some instances have been inexcusable, due both to the failure to gain full cooperation of the patient and to the carelessness or ignorance of doctors in other departments. Experience in handling private patients where the mortality has been nil shows that death following surgical operations on diabetics should not be more frequent than for non-diabetics. In discussing the medical and surgical care of the diabetic patient in a recent bulletin of the Mayo Clinic (Proceedings of the Staff Meetings of the Mayo Clinic, Vol. 9, No. 43, October 24, 1934) Rynearson and Wilder analyze the results of treatment of the 556 diabetics seen there in 1933—a number which represents a continuously increasing incidence of patients with diabetes. Their findings show that on the medical service no patient died from uncomplicated diabetes and they also merely "re-emphasize the fact that diabetes, when properly controlled, is not a contraindication to surgical procedures." They say that the disease, if recognized early and treated correctly, does not constitute a severe hazard and in conclusion they add: "Were it not for the neglected cases and those in which severe complications have developed because of carelessness or other cause, the treatment of diabetes would be comparatively easy."

Experience has taught that hospitalization of diabetics is no longer necessary in order to get them on a suitable diet and determine the amount of insulin necessary for correct treatment. It is also evident from the results obtained in my charity clinic that if we are to handle properly our private diabetic patients, we must control them with a positiveness and severity equal to that which I have attempted to use with the clinic patients. Finally, to handle diabetes satisfactorily, the physician must have more than a superficial knowledge of the disease, its treatment, and the psychology peculiar to it; also, he must give and receive absolute cooperation not only from the patients themselves but also from the other physicians under whose care they may of necessity come.

REMARKS ON SURGERY IN THE MENTALLY ILL*

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In selecting such a title for a paper it is not the intention of the writer to convey the impression that surgery in the mentally sick is a special brand of surgery and differs from surgery as practiced on the non-psychotic individual. For this reason no text books are to be found on the practice of surgery in the psychotic and few articles are to be found in the literature on surgical conditions in the psychotic. It having been my lot to be associated with the psychiatric and surgical service of a large state hospital for a number of years, I have felt that some of my observations and experiences on certain types of the psychotic patient might be of some value.

In the old days of the "insane asylum" (which is not so long ago) when only custodial care was provided, with very little medical attention, surgical conditions were given no notice and an operation on an inmate was an almost unheard of procedure. These helpless people with surgical conditions were left to die or to become chronically physically ill or to recover by nature's processes.

The responsibility in regard to psychotic individuals should imply a great deal more than custodial care and should make use of every known avenue of investigation, with respect to their mental and physical condition.[1] This is particularly true in the early cases, for when recovery does not take place fairly early in the course of treatment, and before mental deterioration begins, the prognosis is less favorable, for it is axiomatic that the longer a patient remains under institutional care the poorer his chances are for making a satisfactory readjustment to community life.

One of the foremost features of any state hospital for the mentally sick should be its sur-

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gical department and service. The surgical department constitutes the heart of the medical and nursing service. It is here and only here that correct principles and practice of asepsis can be taught, and the inculcation of aseptic technique is the best conceivable habit training for nurses and doctors. Without an adequately equipped surgical department the best interests of the patients cannot be served.

Operation in the mentally disturbed may be divided into three classes: first, operation which is indicated for surgical lesions which threaten life; second, operation for lesions which produce irritation to the individual or which upset metabolism, for which the surgeon would operate if the person were sane; and third, operation for minor lesions, such as lacerated perineums; phimosis; retroversions of the uterus; lacerated and infected cervices, etc.[2] Operation on the psychotic should be done only after a careful workup of the individual case and each case studied in all its phases,[3] including the psychiatric phase. It must be kept constantly in mind that each mental patient is first of all a human being and is subject to the same physical disorders common to the mentally sound division of the human family,[4] and justly entitled to the same careful treatment.

Recognizing our limitations in restoring some classes of patients suffering from what are regarded as functional mental disturbances, we should at least accord all the relief possible in a medical and surgical way. We have no right to say that this or that patient is hopelessly insane, and therefore why bother to operate for the relief of a purely surgical condition. It is not, and probably it never will be, the function of the medical men to shorten life or to perform euthanasia unless the end is inevitable and near. Not to attempt to relieve whatever disease that is found in mental patients is to invite deterioration in ourselves and the softening of our moral fiber. If we who are responsible for the care of inmates in a state hospital did not strive to do this conscientiously we would find ourselves merely the guardians of a cess-pool of humanity, with our charges enduring at times the agonies of the damned and perishing miserably and ourselves sinking lower daily in our own estimation. On the contrary, when one cannot hope to accomplish cure or prolong life or relieve suffering and may even contribute to a sudden or speedy ending by surgical intervention, then one is guilty of malpractice if it is chosen but to practice his hand or exhibit his skill and perform an unnecessary operation.[7]

A great many of these patients are admitted to psychopathic or state hospitals in a malnourished, enfeebled condition, and consequently are poor surgical risks. The surgical conditions found in new admissions are usually chronic and attempts are always made to improve the physical health by the usual methods before any operative procedure is carried out. Patients who are excited and uncooperative, and who develop acute surgical conditions can, as a rule, be operated upon successfully and have a satisfactory convalescence. Mechanical restraint may be necessary in some cases but oftentimes a patient who has been uncooperative and violent before operation is quiet and cooperative during convalescence.

Many new patients requiring surgery are admitted to state hospitals and the surgery necessary in the population of about 4,000, (which is the present approximate population of the Florida State Hospital), might be compared to that in a village of 4,000 inhabitants, with a few exceptions. These psychotic individuals develop acute appendicitis, intestinal obstructions, ruptured peptic ulcers, gall-bladder disease, kidney stones, ureteral strictures, acute mastoiditis, fractures of bones, etc. It is true that surgical and diagnostic work on patients of this type is much more exacting than in general practice, since the patients in many instances are incapable of describing their sensations and the surgeon must depend upon his own observations of symptoms.

In the majority of cases, diseases which require surgery are not the etiological factor in the production of a psychosis; however, it is my opinion that in many cases such disease can be and is a precipitating factor, provided there is a proper background or a so-called psychopathic constitution. We have all observed in infections and toxic diseases mental symptoms (excitement, depression, hallucinations, delusions and catatonic states), such as are identified with typhoid, malaria, influenza, pneumonia, etc., that usually disappear following the elimination of the infection. Persons have been observed who become delirious with fever a few degrees above normal. Why do some individuals who appear much more ill physically and more toxic not develop mental symptoms? I do not know the

answer to this question, but it has been stated by some to be an "inherent mental instability" or constitutional predisposition. My belief is that this same inherent quality is present in many of the persons who develop psychoses with other somatic diseases, and perhaps other organic psychoses. It is this type of patient who can often be helped and restored to a useful place in life when disease or irritation can be removed by surgery.

Surgery is only the first step, however, and unless the surgeon recognizes the psychic aspect of the case, the removal of infections, pelvic repairs, etc., will not fully clear up the symptoms. There is still the hypersensitive, unstable, maladjusted personality to deal with and a psychological approach, with psychotherapeutic measures are important features of the treatment.[5] In other words, the disease is the final stimulus; one stimulus alone will have little effect, but another added to it may do a great deal. Everyone's brain probably has a tensile strength just as muscles have. Muscles are able to take care of a certain amount of strain; if more is added they break. It is, therefore, always a good policy to correct everything that is wrong with a patient who is mentally ill. Aristotle has said that epilepsy may be caused by the teeth if the brain is willing. It is believed that the cause of idiopathic epilepsy is in the brain; if the brain is all right one will not have epilepsy, but if a patient with epilepsy is allowed to become constipated, he will have further attacks.[6]

In reporting the following series of 275 operations for pelvic disease that were done on psychopathic white and colored female patients at the Florida State Hospital, no claim is made that surgery cured the mental disease of those who went home and are still absent from the institution, for I do not know what number of them are in other state hospitals, private psychopathic hospitals, prisons, and county jails. It is claimed, however, that the physical health of the majority of the cases with chronic disease improved after surgery and improvement of the mental condition resulted in many instances. In the functional cases, I am sure that a great many would have improved mentally regardless of operation. On the other hand, many who did not improve mentally became less of a care from the nursing standpoint as well as from that of personal hygiene.

The following is a summary of the operations specifying type of mental case in which operations were performed. For the sake of brevity the types of mental cases not classified as functional are classified as other type psychoses. This includes syphilis with psychosis, epilepsy with psychosis, feeblemindedness, constitutional psychopathic disease, toxic psychosis, psychoneuroses, organic psychoses, etc.

1. Laparotomies in which uterine fibroids alone were removed—28, 13 of which were in white females and 15 in colored females; 15 of which were in functional cases and 13 in cases of other types.

2. Laparotomies in which uterine fibroids and diseased appendages were removed 64, of which 11 were in white females and 53 in colored females; 34 of which were in functional cases and 31 in cases of other types.

3. Laparotomies in which diseased uterine appendages alone were removed, 135, of which 80 were in white females and 55 in colored females; 53 of which were in functional cases and 82 in cases of other types.

4. Laparotomies in which diseased uterine appendages were removed and correction uterine displacements made, 40, of which 35 were in white females and 5 in colored females; 12 of which were in functional cases and 28 in cases of other types.

5. Laparotomies for correction uterine displacements, only 2; both in white females, one of which was in a functional case and one in a case of another type.

6. Laparotomies in which diseased uteri were removed 6; in two of which diseased appendages were also removed; 3 of these cases were in white females and 3 in colored females; 2 of which were in functional and 4 in other type cases.

Appendices were removed in 257 of the above cases.

CONCLUSIONS

The following conclusions can be drawn from the above:

1. One hundred and thirty-one of the operations for pelvic pathology were in colored females, and 144 in white females, which would indicate in regard to this series and according to the proportion of total admission of white females and colored females, that pelvic pathology is more common in colored females who are mentally ill that in white females similarly affected.

2. Ninety-two cases out of the 275 had fibroid uteri removed or fibroids excised. Sixty-eight were in colored females and 24 in white females. This would indicate that fibroid uteri are found about three times as frequently in colored females as in white females.

3. Since 92 fibroid uteri were found in 275 psychopathic females, which is about one-third, it might be stated with certain reservations that fibroid uterus is a common condition in pelvic disorders in the mentally ill.

4. Of the fibroid tumors found 36 were in functional mental cases in colored females and 32 in other type mental cases, colored females. Thirteen were in functional mental cases in white females, and 11 in other type mental cases in white females. Therefore, a total of 49 fibroids out of 92 were found in functional mental cases; 36 in the colored females and 14 in the white females. Thirty-two out of 42 of the fibroids in other type psychoses were found in colored females.

5. Of the total number of laparotomies for pelvic disease, 58 were done on white females with functional mental disease, and 89 on white females with other types of mental disease. Fifty-eight of the laparotomies were done on colored females with functional mental disease and 70 on colored females with other types of psychoses. Pelvic disease was, therefore, found in 116 cases of functional psychoses and 159 in other types of psychoses in this series.

Mortality in this series of cases was four:

1. One colored female died suddenly during closure, whose condition had apparently been good; respiration ceased suddenly; death was presumably due to pulmonary embolism.

2. One colored female died of general peritonitis, onset 12 days postoperative.

3. One colored female died of general peritonitis, onset 5 days postoperative, following complete hysterectomy for malignancy of cervix, which was well advanced and made difficult the proper preparation of the vagina. This patient was also luetic.

4. One colored female, a case of cerebrospinal syphilis, died 6 days postoperative of colitis, origin undetermined. This patient was in the beginning a poor surgical risk and was operated on due to pressure symptoms from a rather large uterine fibroid.

One colored female, with pelvic pathology and not included in this series, died of respiratory paralysis following spinal anesthesia (spinocaine) as incision was being made. This was in the comparatively early days of spinal anesthesia, when little was known of the management of such conditions. This patient had syphilis and her mental condition had become clear under antisyphilitic treatment. We were not aware at that time that any meningeal irritation was a contraindication to spinal anesthesia.

INTERESTING OBSERVATIONS

An interesting observation regarding surgical lesions in the psychotic is that as a rule the patient makes little complaint of pain. Lesions which produce great pain are frequently borne uncomplainingly and discovered only on examination; this seems to be particularly true in women with gynecological lesions.

It has also been repeatedly observed that psychotic patients do not complain of as much postoperative pain as do persons who are normal mentally, and require only small doses of narcotics. I have observed many postoperative laparotomies in which the patient had not more than a total of 2 1/6 grains of morphine.

Postoperative abdominal distention as a rule is not marked and is easily controlled. Cases of paralytic ileus were absent in this series.

Out of the total of 275 laparotomies there have been four separations of abdominal wound due to patients getting out of bed. These people must be watched carefully as a rule and at times restrained mechanically to prevent their getting out of bed. On the other hand, numerous patients who have been disturbed and uncooperative before operation make excellent patients after operation.

Frequently a patient will improve mentally while seriously ill or following an operation only to become disturbed again mentally upon physical improvement.

SUMMARY

1. Surgery is practical and advisable for the insane with operable conditions as well as being an important aid in the constructive and progressive care of the insane.

2. Surgical procedures among the functional group of psychoses are conceded to be useful adjuncts to the general welfare of the patients, but as a rule whatever glowing reports have appeared have not received much corroborative evidence. The prevailing opinion is that a diseased viscus in a functional psychosis should receive the same care and attention that it does

in any individual, quite apart from any other clinical situation that may be concurrent. Mental patients likely feel more at ease when physical abnormalities of an irritating, aggravating and incapacitating nature are taken care of than do those patients who do not possess a mental disorder in a formal sense.

It is my opinion that functional mental disturbances cannot be solved by surgery, but will have to be solved by chemistry and physiology.

3. There is no question that focal infection may aggravate borderline mental cases and produce various mental disturbances; and that in these cases surgery can play an important part in relieving the psychosis.

4. Surgery upon the mentally ill produces no evil results if not mutilating and if done for definite lesions after the patient has been put in the best physical condition. Such a policy in a psychiatric hospital is certainly not an overemphasis of surgery.

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WHERE THE FIELD OF THE OCULIST MEETS THAT OF THE PRACTITIONER*

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In addressing you today, I wish to present the thought that the family physician could make use of the electric ophthalmoscope in his daily practice and become as familiar with its use as with the stethoscope or any other instrument in his armamentarium. He may thus combat that feeling which prompts him to shrink from all cases of injury or diseases of the eye, and not neglect the opportunities for making an early diagnosis when immediate treatment is essential to prompt recovery. As a general rule, the family doctor first sees these cases and if today I can encourage one or more of the general practitioners to agree with me, or provoke a discussion which will prove the correctness or fallacy of my suggestion, I shall feel that I have encouraged some constructive action for our general benefit.

The field of the oculist seldom meets that of the family doctor in this day and time except in railroad practice. Specialism has grown rapidly in all branches of medicine during the last 30 years and has been greedily absorbed by the public.

Nearly forty years ago I did a good general practice in a city of 60,000, where one of the older and more experienced physicians had a wealthy patient who was very ill. Two close friends of this patient were much alarmed about his condition and it was my privilege to listen to their remarks: One said, "Mr. Gray had a specialist to see him today." "Well," replied the other, "I never knew a specialist to do anything except to charge a very special price and generally collect it in advance." From this it would appear, brother doctors, that specialists of long ago were at least good business men.

There has been a change of opinion since that time, if not in fee. No more is the general practitioner looked upon as a cure-all and adored by his clientele as in the gay nineties, which some of you may remember. Today there is probably no condition which takes more patients from the general practitioner to the oculist than headache and it must be admitted that eyestrain is often an unsuspected source of headache though the patient may have perfect vision. These headaches may be frontal, occipital, or, according to some oculists, across the vertex, though "across the vertex" is more generally advanced by the gynecologist. However, Casey Wood made no exception of the vertex.

Usually the thing that calls the family doctor into the so-called field of the oculist is an injury to the eye. His first guide is the patient's vision. If the vision appears to be normal, the pupil active and equal in size to the opposite pupil, there is little to be feared, but nevertheless an examination should be made with the ophthalmoscope and the usage of an electric ophthalmoscope is so simple that any doctor or even a nurse can easily master it. At present I have two office girls either of whom is able to recognize abnormal fundi with this instrument. A good nurse is able to render valuable assistance in eye, ear, nose and throat work, as in general practice or surgery.

Occasionally the family doctor is called to

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treat a condition that the patient terms a "sore eye" which may or may not prove to be iritis. The doctor may give expectant treatment. He may hesitate to give atropine. He may not be sure it is iritis and suspect glaucoma, and it may not be convenient for the patient to go to the oculist because of distance or lack of funds. Now, if that family doctor had mastered the technique of the luminous ophthalmoscope, he would have gained confidence in himself and have favorably impressed the patient as well. By its use, he will so increase his knowledge about conditions of the eye that the oculist's office will not be filled, as at present, with many simple cases. The case that is promptly and properly diagnosed has every advantage.

Acute glaucoma, for instance, is a condition that is frequently overlooked in general practice, since there is unilateral pain in the head and behind the eye. A similar pain may be present in iritis but the presence of a large fixed pupil, the cloudy cornea, poor vision, stone-like feeling of the globe and the shallow anterior chamber, should make a diagnosis, with aid of reflected light and ophthalmoscope, a simple one. Again, the family doctor is called to remove foreign bodies from the cornea which may be easily overlooked. The patient may insist there is still some trash in the eye, so it is necessary to make a careful examination with a focal light ophthalmoscope and with 2% of fluorescein or 1% mercurochrome, in order to be sure that no abrasion of the cornea or minute ulcer be overlooked.

Owing to the carelessness of some patients, it may be dangerous to prescribe eye drops for use at home. Some years ago a man came to my office one morning about 9 a. m. No foreign body, only a slight chalky deposit on left upper lid, easily removable, was found. I gave him a prescription for a 5% solution of neosilvol with directions to use it three or four times daily. About 5:30, he called up and said that the medicine was burning his eye out. He came to the office with the cornea of his eye a brownish red as if a fire brand had touched it, but did not think to bring his medicine. I told him to bring it next day, and it was apparent that this medicine was the medicine that I had prescribed. Then in order to save the druggist from unjust criticism and to prove that it could not possibly have been this medicine which burned the eye but some other that he had used by mistake, I put a drop in my own eye in the presence of himself and his wife, but they would not admit that any other medicine had been used in his eye and they, to this day, blame that druggist for the fact that the eye still has a nebulous appearance.

The family doctor can know many of the essentials of the eye and the patient has a perfect right to expect him to know these essentials well enough to be able to judge whether his trouble is serious and whether an oculist should be consulted. Such service may cost oculists some practice but it is, nevertheless, a service that the patient has a right to expect from his true friend, his family doctor.

In conclusion allow me to state that I know of no better way for the doctors in small towns to hold their clientele with railroad connections than the adoption of the practice, when making routine or general examinations, of examining the eyes with an electric ophthalmoscope and thus becoming as familiar with its use as is a neurologist who depends a great deal on ophthalmoscopic examinations in diagnosis.

OUR NEXT STATE MEETING

A BIG BOAT *A BIG CROWD* *A BIG TIME*

SEE ADVERTISEMENT ON COVER OF THIS ISSUE

The Convention Cruise

The convention boat, the S.S. "Florida," links the two most amazing tropical cities in our hemisphere and members of the Florida Medical Association are looking forward to the sea trip.

Since the S.S. "Florida" sails in the morning hours, most conventioneers will wish to arrive a day, perhaps more, ahead of the opening date to revel in the tonic delights of America's marvelous convention city. In magic Miami, where nature furnishes a background of wonderland scenery, man has added unique charm, varied industry and every recreational facility, save that of ice sports.

This modern miracle, Miami, which, a brief forty years ago was an Indian trading post, a mere crossroads with a "Gen'l Store" to serve its handful of white settlers, is today a leading metropolis, gathering place of the rich and famous, recreational hub of North America, sports center and week-end resort of business men from the north, east and middle west. "Meet Me at Miami", becomes more and more the national open sesame to a grand and glorious holiday world. And all this has enhanced its native glamour and scenic beauty.

Too much rich charm to be enjoyed in one day . . . yet no convention member would miss seeing the Pan American International . . . the world's largest airport on Dinner Key, or the Tropical Gardens, with their weird and beautiful exotic plants; or Royal Palm Park with its wealth of trees and shrubbery and strange West



(1) A market street in downtown Havana. (2) The gay crowd of a boulevard cafe. (3) Cuba's beautiful $20,000,000 Capitol building. (4) Native cafe in Havana. (5) Open-air market. (6) Beautiful residences adjoin the famous golf course of the Havana Country Club.



The white-walled city glistens in the setting sun

Indian plants. There is, too, the scenic drive through miles of the finest residential suburbs in America, palatial homes of the wealthy, cozy cottages of the artistic colonies, stately mansions, pert bungalows, all typifying in their own way the dynamic and striking styles of architecture indigenous to the tropic clime. Nor will he overlook the opportunity to peek in on the famous night clubs with their riot of color, gaiety and music. Even those members who, as native Floridians, think they "know all about that," will glory in Miami this special time of year as they share in the comradely good cheer of their fellow physicians; while those who "never have got down that way" have a treat in store.

The convention really begins as the members step up the gangplank to the spacious decks of the S.S. "Florida", the perfectly appointed luxury cruise ship, for two days of meetings and addresses under the most ideal conditions imaginable. The S.S. "Florida", in addition to satisfying all the exacting requirements of discriminating travelers, for comfort, convenience and luxury of accommodation, is particularly suited for a convention ship because of the extra spaciousness of its public rooms, the veranda ballroom, the smoke-room, the writing and dining rooms as well as the open sun deck. The promenades, the numerous wide halls and stairways that give free access to all parts of the ship, evade that sense of jostle and crowd so trying to many. Paramount to her beauty and suitability, the S.S. "Florida" rates her construction. Built under the most rigid provisions for safety, completely modern in respect of fire protection, radio equipment, adequate lifeboat provision and a trained crew, the S.S. "Florida" is the convention boat de luxe.



A typical sidewalk cafe in Havana

So, as the coast of Florida goes down astern with the setting sun after the first day's serious sessions, the S.S. "Florida" bears her convention members pleasure-bound through the tropical spring night. No danger of storms or hurricanes at this hour of the year! Not in nearly half a century of official weather bureau records has there been other than balmy weather the last week in April or early May.

Continuing her cruise for another full day of sun and ocean breezes, the S.S. "Florida" circles in the sapphire waters of the Caribbean while, in unusual and delightful surroundings, the scientific meetings continue and reports are made to the convention.

The boat reaches Havana in the early afternoon of April 28, giving a long period for sightseeing, golf and shopping, and a long evening that may be well spent in any way the individual members consider "well." All in holiday mood, the members may do almost anything and probably will. Before the midnight sailing they may wander in the gay, worldly, atmosphere of the Prado, that wonder of boulevards, two miles long and magnificently wide, where all society promenades.

In fact, the whole experience of Havana, from the moment of stepping down the gangplank, is fraught with thrills, and a sense of "difference" in the environment. The smile of the Customs official bespeaks friendliness, and makes travel-

ers feel welcome in this land of gorgeous adventure and the limber elbow. Convention members disembarking from the S.S. "Florida" hear the clamorous, staccato voice of the City, the hum of motors, the baying of steamer whistles in the harbor; the blurred, musical intonations of the newsboys and perhaps a fragment of music thumped on guitars, tympani and rattling gourds. They catch tantalizing vistas of narrow streets with tall grilled windows and brass-studded doors, and many signs with curious names and messages in Spanish. Those who do not know a word of Spanish need not worry, for always someone is at hand—policeman, waiter, chauffeur, hotel clerk or guide—who speaks English and will translate wishes into solid enjoyment.

From the welter of commercial streets near the docks, the travelers emerge into a broad asphalt boulevard that fairly startles with its luxury and beauty, its shady park way, its soaring facades of white marble, handsome clubs, magnificent theatres, sidewalk cafes, statues, hotels, restaurants and government buildings. Dominating the Prado in Havana is the splendid new Capitola, reminiscent of America's own Capitol.

Havana has a dual nature. Nowhere in the world is there a city quite like this, where the transition from one personality to the other is so palpable. Here is a city with a night-time mood quite different from that of its daytime hours. About the cocktail hour, when the little teeming streets grow cool with shadows, a profound spiritual change is working throughout the city. The day of work, of typewriters and telephones and ledgers, is terminating. A spirit of joyousness invades the streets, the hotels, the shops, the bars. People are relaxing from the tension of business. A mounting expectancy of happiness is abroad. And this hour the convention members may share. Provision is made for dinner on board ship, for those who wish it, but most will doubtless avail themselves of the luxury of some hotel roof garden, where they may watch the fires of the dying day painting the tiles of the city with farewell splendor, and then the swift descent of tropic night.

Night-time in Havana . . . a demi-tasse, a fragrant "vuelta abajo" cigar, smoked in respectful leisure, and the seductive rhythms of a "son" orchestra calling to the toes to tap a bit. You go places and see things and can follow a score of diversions in daytime Havana; but at night you sense more acutely the subtle change when living becomes a glorious adventure.

Some members will undoubtedly wish to visit old Morro Castle sitting gloomily at the mouth of the harbor and brooding over the dark and bloody deeds it has witnessed; the tunnels and dungeons of Cabanas fortress, adjoining Morro; the tangle of narrow streets and glorietas of old Havana, where once resounded the clank of cavaliers' swords, and so back to the boulevards and handsome facades of the modern city.

A special sightseeing trip has been planned for the members of the Florida Medical Association while in Havana. This tour will afford the opportunity of thoroughly seeing the business and residential sections of the city as well as historical buildings, cathedrals, cigar factories and the interesting club buildings for which Havana is famous.

Members, after the evening in the city, return to the boat for the midnight sailing. And so, on the good ship "Florida", with glamour at its height, the convention proper comes to a cheerful climax of gaity and goodwill and profitable, serious work as members return to Miami.

Long will the members of the Florida Medical Association talk of their unique experience of the cruising convention of 1936 . . . and the real thrill of foreign travel packed into one handy, portable, three-day convention.



Entering Havana harbor

PROGRAM

of the

SIXTY-THIRD ANNUAL MEETING

of the

FLORIDA MEDICAL ASSOCIATION, Inc.

TO BE HELD ON THE S.S. "FLORIDA"

APRIL 27, 28 and 29, 1936

INFORMATION

Information desk will be located in the Assistant Purser's office on "B" Deck. Members and guests will not be required to re-register after boarding ship as the roster in the Purser's office will be used to complete the list of those who are registered for the meeting.

Since there will be no official sessions from Tuesday noon until Wednesday morning, there will be no time for an Association dinner. The Committee on Arrangements has, therefore, not prepared for an official Association dinner during the convention.

TECHNICAL EXHIBITS

Technical exhibits will be located in various convenient places in the halls. Exhibit space is very limited; therefore, only a few of our regular exhibitors have made special request for the privileges this year. We hope that next year all of our regular exhibitors will occupy their usual places in the headquarters' hotel.

The following firms have arranged for exhibits on the S.S. "Florida":

American Optical Co.
C. B. Fleet Co.
Mead Johnson & Co.
M. & R. Dietetic Laboratories.
Philip Morris & Co., Ltd.

ENTERTAINMENT

No attempt will be made to list the various entertainment features that are in store for the members and their guests. In the first place, there is not space in the program for a complete resume of the plans that have been worked out for the entertainment and pleasure of those making the trip. In the second place, it may be more interesting to have some of the events as surprises. Your committees and the officials of the P. & O. Steamship Company have exerted themselves to make this trip a success.

In Havana, cars will be provided for a number of interesting sightseeing trips and there will be ample time for visiting places of interest and for shopping. No set schedule has been planned for the visit to Cuba so all will have an opportunity to vary their excursions as desired. Those desiring supper on board ship will find everything in readiness and those who would prefer dining in Havana at their own expense will have the opportunity.

GOLF

Doctors who wish to play golf are requested to see Dr. Blackburn W. Lowry, President of the Florida Medical Golf Association, as soon as possible after boarding ship. Arrangements have been made for cars to meet the boat and carry the players to the Havana Country Club. Mr. Juan Sabates will make the cruise and personally conduct the players to the Havana Country Club. Mr. Sabates is President of the Cuban National Tourist Commission and is directly responsible for having made the arrangements with proper officers of the Havana Country Club for use of the course by members of the Florida Medical Association who wish to play golf. Mr. and Mrs. Sabates will make the trip from Havana to Miami and will be with the Association on its trip from Miami to Havana. In addition to bringing personal greetings from the Republic of Cuba, he will issue to those who so desire, tickets that will entitle them to play golf at the Havana Country Club. We have been informed that this course is a golfer's dream. The Golf Committee has made elaborate plans for a pleasant afternoon.

All members participating in the golf tournament are asked to bring their handicaps, signed by their club secretary or club professional. No handicap of over 27 will be allowed. Please turn in your handicap promptly after boarding ship to Dr. Blackburn W. Lowry, chairman of the Committee.

Prizes for the tournament will be presented as follows:

1st prize: Orlando Cup (low net score).

2nd prize: Runner-up (2nd low net score), gentleman's genuine Monte Cristo Panama hat, donated by Mr. P. J. Saunders, President of the P. & O. Steamship Company.

3rd prize: (Low gross medal score), combination ophthalmoscope and otoscope, donated by the Southeastern Optical Company.

4th prize: (2nd low gross medal score), physician's leather bag, donated by Mr. Henry Parramore, President of Surgical Supply Company.

5th prize: (Blind Bogey), combination thermometer, barometer and humidity gauge, donated by American Optical Co.

FISHING

Fishing trips for individuals or groups will be arranged before or after the cruise in Miami. The P. & O. Steamship Company will arrange to use some of their lifeboats for fishing, if needed. If you are planning a fishing trip, please communicate with Dr. M. J. Flipse.

COMMITTEE ON BOAT TRIP

J. Knox Simpson, Chairman, Jacksonville.
Frank D. Gray, Orlando. Homer L. Pearson, Miami.
Walter C. Payne, Pensacola. Joseph W. Taylor, Tampa.

COMMITTEE ON PROJECTING LANTERN

Frazier J. Payton, Miami Beach.

GOLF COMMITTEE

Blackburn W. Lowry, Tampa.
William S. Manning, Jacksonville.

LADIES' ADVISORY COMMITTEE

Gordon H. Ira, Jacksonville.

SCIENTIFIC ASSEMBLIES

Committee on Scientific Work: Leigh F. Robinson, Ft. Lauderdale; C. C. Webb, Pensacola; Thomas M. Palmer, Jacksonville; John R. Chappell, Orlando; George Dame, Inverness; Blackburn W. Lowry, Tampa.

Attention is called to the following By-Laws:

"All papers read before the Association shall be its property. Every paper shall be deposited with the Secretary when read."

"No address or paper before the Association, except those of the President and Orator, shall occupy more than fifteen minutes in its delivery, and no member shall speak longer than five minutes, or more than once on any one subject."

The Dade County Medical Society has offered its projecting lantern and daylight screen for use during the convention. Mr. M. H. Weaver will look after the showing of slides for essayists.

FIRST SCIENTIFIC ASSEMBLY

Monday, April 27, 2:00 P. M.

DINING ROOM

1. "Present Day Conceptions of the Management of Prostatic Obstruction", Louis Orr, Orlando.

   An analysis of over 14,000 cases of prostatic resection performed in the past five years in this country, including the opinions of the operators, giving an accurate conception of the present day management of prostatic obstruction. It is the writer's opinion that the judgment and experience of the surgeon will largely supplement the commercialization of various operative procedures designed on the prostate.

   Discussion: Eugene S. Gilmer, Tampa; Robert P. Henderson, Orlando.

2. "The Cautery in Acute Epididymitis and Orchitis", J. C. Vinson, Tampa.

   Technic of the cautery puncture in acute epididymitis and orchitis; the valuation of the results since the original report of the procedure; indications for the method; and end results.

   Discussion: Roy J. Holmes, Miami; Robert B. McIver, Jacksonville.

3. "Collapse Therapy of Pulmonary Tuberculosis", Louie Limbaugh, Jacksonville.

   "The Surgical Treatment of Pulmonary Tuberculosis", Kenneth A. Morris, Jacksonville.

   Discussion and Demonstration of X-ray Films, W. M. Shaw, Jacksonville.

   Moving Picture: "The Surgical Treatment of Pulmonary Tuberculosis."

   Discussion: General.

4. "Sulphur, the Forgotten Remedy", Hubbard Gates, Bradenton.

   Early use in medicine; my first use in 1893; most remarkable results in chronic neuritis and arthritis; my theory as to the bio-chemical process of elimination; not good in focal infection; changes the flora and intestinal bacteria; sulphur is a natural element of the body; helps elimination of the amino acids in the form of indican.

   Discussion: Arthur Weiland, Coral Gables; T. M. Rivers, Kissimmee.

FIRST GENERAL SESSION

Monday, April 27, 4:00 P. M.

DINING ROOM

Call to Order, President Herbert L. Bryans.

Introduction of Georgia Delegates, Dr. Arthur G. Fort and Dr. C. F. Holton.

Reports of Committees:

Committee on Legislation and Public Policy, Robert B. McIver.

Hospital and Medical Education Committee, Julius C. Davis.

Committee on Necrology, C. D. Christ.

Public Relations Committee, J. Ralston Wells.

Committee on Post-Graduate Work, T. Z. Cason.

Committee on Cancer Control, F. Clifton Moor.

Committee on Medical Economics, J. S. Turberville.

Advisory Committee to Woman's Auxiliary, Gordon H. Ira.

Inter-Relationship Committee, William M. Rowlett.

Tuberculosis and Public Health Committee, M. J. Flipse.

Feeble-Minded and Venereal Disease Control Committee, Henry Hanson.

Committee on Maternal Welfare, Homer L. Pearson.

Delegate to A. M. A., Meredith Mallory.

FIRST MEETING OF HOUSE OF DELEGATES

Monday, April 27, 8:00 P. M.

VERANDA BALLROOM

President Bryans in the Chair.

Roll Call and Seating of Delegates.

Adoption of Minutes as published in May, 1935, Journal.

Election of one delegate and one alternate to A. M. A. meeting for two-year terms.

Consideration of proposed amendments to Constitution.

Selection of meeting place, 1937 (provided constitution is NOT amended).

Reading of Resolutions.

New Business.

Announcements.

Adjournment.

SECOND GENERAL SESSION

Tuesday, April 28, 9:00 A. M.

DINING ROOM

Call to Order, Herbert L. Bryans, President.

Reports of Officers and Committees:

Secretary-Treasurer-Editor, Shaler Richardson, and Business Manager, Stewart Thompson.

Executive Committee, Edward Jelks.

Council, Toliver M. McDuffee.

Presidential Address, Herbert L. Bryans, Pensacola.

Address (by invitation),

SECOND SCIENTIFIC ASSEMBLY

Tuesday, April 28, 10:30 A. M.

DINING ROOM

5. "Treatment of Eye Diseases by the General Practitioner", Ralph E. Russell, Ocala.

   Treatment of common diseases: acute conjunctivitis, [illegible] or [illegible] deeper, foreign bodies in the eye. Use of atropine. Glaucoma.

   Discussion: Sherman B. Forbes, Tampa; Bascom H. Palmer, Miami.

6. "Progress Toward Lessening Maternal Morbidity and Mortality", W. C. Roberts, Panama City.

   Discussion in brief of some things we are forgetting that will tend to lower the morbidity and maternal rates in Florida. Mention of some things that are practical and, if adhered to, will aid in this cause.

   Discussion: L. M. Rozier, West Palm Beach; William M. Rowlett, Tampa.

7. "Management of Peptic Ulcer", P. B. Welch, Miami.

   This paper will deal with two main headings: 1. The first problem is to discover, if possible, and remove the possible or probable cause of the ulcer. Under this heading will be discussed (A) the common theories as to etiology, (B) etiology of ulcer predicated upon the hypo-

thesis of infection plus trauma. 2. Management directed to the re-establishment of normal function. (A) The routine management of simple peptic ulcer, under which heading will come diet, medication and correction of habits. (B) Complicated peptic ulcer. (C) Surgical indications and also possibly a few important suggestions as to the essential preparation for surgery.

Discussion: J. Knox Simpson, Jacksonville;
Roy O. Cooley, West Palm Beach.

8. "The Systolic Murmur: Its Interpretation", S. Marion Salley, Miami.

A discussion of those cases where a systolic murmur is present with no other evidence of organic heart disease. To urge careful analysis of such cases to rule out rheumatic fever, hypertension, hyperthyroidism, anemia and neurocirculatory asthenia. A plea not to condemn patient as a cardiac solely because systolic murmur is present.

Discussion: Frank R. Morrow, Miami;
T. Z. Cason, Jacksonville.

SECOND MEETING OF HOUSE OF DELEGATES

Wednesday, April 29, 9:00 A. M.

VERANDA BALLROOM

Unfinished business.

THIRD SCIENTIFIC ASSEMBLY

Wednesday, April 29, 10:00 A. M.

DINING ROOM

9. "The Role of Sinusitis in the Production of Cough", Joseph W. Taylor, Tampa.

The importance of investigating the sinuses in all cases where cough is a symptom or cases that have repeated or prolonged colds accompanied by bronchitis or bronchiectasis. The early diagnosis of sinusitis of which cough may be the only symptom. Acute sinusitis treated prevents chronicity. Lantern slides.

Discussion: Charles J. Heinberg, Pensacola;
W. Jerome Knauer, Jacksonville.

10. "Trigeminal Neuralgia", H. Hamilton Cooke, Miami.

A brief historical resume with a practical consideration of the diagnosis and differential diagnosis. The various types of therapy will be considered in detail. A new instrument designed by the author for electro-coagulation of the branches of the trigeminal nerve will be demonstrated and its value discussed.

Discussion: Paul Kells, Miami;
John W. Snyder, Miami.

11. "Brain Surgery and Epilepsy", J. G. Lyerly, Jacksonville.

A discussion of certain lesions of the central nervous system which are associated with convulsions and benefited or relieved by some surgical operation. Many cases of convulsions, often generalized in character, are due to focal lesions of the brain, caused by glia scars, neoplasms, abscesses, cysts or some zone of cortical hyperirritability, secondary to old inflammatory or traumatic pathology. Lantern slides.

Discussion: H. Mason Smith, Tampa;
T. Earl Moore, Miami.

12. "The Value of Skeletal Traction, Especially in Fractures About Joints," Prescott LeBreton, St. Petersburg.

Due to automobile injuries, cases of severe comminuted or compound fractures are becoming more freqeunt. Those involving important joints are often difficult to handle. Illustrated cases are cited to show different problems in varying solutions.

Discussion: Frank L. Fort, Jacksonville;
W. C. Payne, Pensacola.

THIRD GENERAL SESSION

Wednesday, April 29, 12:00 Noon

DINING ROOM

President Bryans in the Chair.
Unfinished Business.
New Business.
Election of President-elect.
Election of First Vice-President.
Election of Second Vice-President.
Election of Third Vice-President.
Election of Secretary-Treasurer and Editor of Journal.
Presentation of Past-President's Button by Dr. L. M. Anderson, Lake City.
Dr. O. O. Feaster escorted to the Chair as new President.
Adjournment.

COMMITTEE MEETINGS

Executive Committee

To Elect a Chairman.

VERANDA BALLROOM

Scientific Work Committee

To Elect a Chairman.

VERANDA BALLROOM

PROGRAM FOR WOMEN

Registration Committee

Mrs. S. M. Copeland — Mrs. R. D. Ferguson

Social Committee

Mrs. Arthur Walters, Chairman.

Monday, April 27th

11:00 a.m. Executive Board Meeting.
Room "V", Salon Deck

Tuesday, April 28th

9:00 a.m General Business Meeting.

VERANDA BALLROOM

Wednesday, April 29th

11:00 a.m. Post-Convention Board Meeting.

VERANDA BALLROOM

SEVENTEENTH ANNUAL MEETING OF THE FLORIDA RAILWAY SURGEONS' ASSOCIATION

Monday, April 27, 9:30 A. M.

DINING ROOM

OFFICERS

President, Leland F. Carlton.....Tampa
President-elect, T. M. McDuffee.....Manatee
Vice-President, J. Ralston Wells.....Daytona Beach
Secretary-Treasurer, H. D. Clark.....Fort Pierce

COMMITTEES

Executive

J. W. Alsobrook, Chairman.....Plant City
H. C. Dozier .....Ocala
T. W. Hutson .....Miami

Scientific Program

A. R. Beyer, Chairman .....Tampa
Hugh West .....DeLand
H. A. Walker .....Miami Beach

Necrology

Hubbard Gates, Chairman.....Bradenton
J. A. Strickland .....St. Petersburg
W. E. VanLandingham .....West Palm Beach

FIRST ANNUAL MEETING OF THE FLORIDA PEDIATRIC SOCIETY

President, Luther W. Holloway.....Jacksonville

Vice-President, William E. Ross.....Jacksonville

Secretary-Treasurer, Warren Quillian..Coral Gables

Monday, April 27, 9:30 a.m.

SMOKING ROOM

1. "Orthopedic Surgery In Childhood," Arthur H. Weiland, Coral Gables.
2. "Relationship of General Medicine to Pediatrics," Wm. W. Anderson, Associate Professor of Pediatrics, Emory University, Atlanta, Georgia. (Invited guest.)
3. "Relationship of General Surgery to Pediatrics," Walter C. Jones, Miami.

Informal round table discussion groups (physicians will indicate their preference before the meeting in order that proper seating facilities may be arranged.)

A. "Blood Dyscrasias in Infancy and Childhood," Thos. E. Buckman, Leader, Jacksonville.

B. "Respiratory Infections in Infancy and Childhood," Gilbert S. Osincup, Orlando.

C. "Diseases of the Newborn," Wm. W. Anderson, Leader, Wm. W. McKibben, Assistant, Miami.

It is hoped that there will be considerable interest and enthusiasm in this type of presentation and that many members of the state Association who are interested will take an active part in the discussions.

FIFTH ANNUAL SPRING MEETING OF THE FLORIDA RADIOLOGICAL SOCIETY

OFFICERS

President.....W. McL. Shaw, Jacksonville

Vice-President .....F. J. Payton, Miami Beach

Secretary-Treasurer .....Gerard Raap, Miami

McAllister Hotel
Biscayne Boulevard and Flagler Street,
Miami,
April 26, 1936

10:00 a.m. Scientific Session.

1:00 p.m. Luncheon.

2:30 p.m. Election of Officers and Business Meeting.

8:00 p.m. Scientific Session.

Adjournment.

PAST PRESIDENTS

1884—Dr. John P. Wall, Tampa.*
1885—Dr. N. D. Phillips, Gainesville.*
1886—Dr. Joseph Porter, Key West.*
1887—Dr. J. W. Hicks, Orlando.*
1888—Dr. R. A. Lancaster, Gainesville.*
1889—Dr. R. P. Gary, Ocala.*
1890—Dr. J. Harris Pierpont, Pensacola.
1891—Dr. Sheldon Stringer, Brooksville.*
1892—Dr. R. A. Lancaster, Gainesville.*
1893—Dr. J. D. Rush, Apalachicola.*
1894—Dr. R. P. Daniel, Jacksonville.*
1895—Dr. C. B. Sweeting, Key West.*
1896—Dr. H. K. DuBois, Port Orange.*
1897—Dr. R. B. Burroughs, Jacksonville.*
1898—Dr. R. P. Izlar, Ocala.*
1899—Dr. J. Harrison Hodges, Gainesville.
1900—Dr. W. H. Hughlett, Cocoa.*
1901—Dr. J. Harris Pierpont, Pensacola.
1902—Dr. J. Harris Pierpont, Pensacola.
1903—Dr. DeWitt Webb, St. Augustine.*
1904—Dr. E. N. Liell, Jacksonville.*
1905—Dr. J. M. Jackson, Miami.*
1906—Dr. John MacDiarmid, DeLand.*
1907—Dr. W. P. Lawrence, Tampa.*
1908—Dr. J. F. McKinistry, Gainesville.*
1909—Dr. Henry E. Palmer, Tallahassee.
1910—Dr. J. D. Love, Jacksonville.*
1911—Dr. A. H. Freeman, Ocala.
1912—Dr. John S. Helms, Tampa.*
1913—Dr. P. C. Perry, Jacksonville.*
1914—Dr. F. C. Moor, Tallahassee.
1915—Dr. R. H. McGinnis, Jacksonville.
1916—Dr. E. W. Warren, Palatka.*
1917—Dr. Ralph N. Greene, Jacksonville.
1918—Dr. F. J. Walter, La Mesa, Cal.
1919—Dr. Wm. E. Ross, Jacksonville.
1920—Dr. W. P. Adamson, Tampa.
1921—Dr. S. R. M. Kennedy, Pensacola.*
1922—Dr. L. M. Anderson, Lake City.
1923—Dr. H. Marshall Taylor, Jacksonville.
1924—Dr. John C. Vinson, Tampa.
1925—Dr. John S. McEwan, Orlando.
1926—Dr. H. Mason Smith, Tampa.
1927—Dr. John A. Simmons, Arcadia.
1928—Dr. F. J. Waas, Jacksonville.
1929—Dr. Henry C. Dozier, Ocala.
1930—Dr. Julius C. Davis, Quincy.
1931—Dr. Gaston H. Edwards, Orlando.*
1932—Dr. Gerry R. Holden, Jacksonville.
1933—Dr. William M. Rowlett, Tampa.
1934—Dr. Homer L. Pearson, Miami.
1935—Dr. Herbert L. Bryans, Pensacola.

*Deceased.

PATRONIZE

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Florida Medical Association, Inc.

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GRADUATE SHORT COURSE, JUNE 22-27, 1936

A special feature of this year's Graduate Short Course for Doctors of Medicine, to be held at the University of Florida, Gainesville, from June 22 through June 27, will be the evening meetings. Because most of the physicians taking the course wished to remain in Gainesville during the evenings, many requests were received by the committee for more evening sessions, similar to the symposium on Malaria last year.

Two symposia have been arranged, one on Respiratory Diseases for Monday evening, June 22, and the other on Fractures for Thursday evening, June 25. Each symposium will be composed of three papers. The speakers on Respiratory Diseases will be Dr. W. Atmar Smith of Charleston, South Carolina, Dr. Herschel C. Crawford of Atlanta, Georgia, and Dr. M. Jay Flipse of Miami. Presenting papers on Fractures will be Dr. H. Earle Conwell of Birmingham, Alabama, Dr. Frank L. Fort of Jacksonville, and Dr. Arthur H. Weiland, Coral Gables.

In addition to the symposia, there will be round-table discussions on Tuesday evening, June 23, and Friday evening, June 26. On these occasions, the lecturers will be given twenty minutes each in which to answer those questions previously turned in by the physicians taking the course. These discussions will replace the luncheon meetings of former years.

Members of the committee have expressed themselves as well pleased with the program for this year, which will be essentially the same as the one last June which proved so popular. The complete program will soon be mailed to Florida physicians. Lecturers who will present courses are as follows: Dr. O. W. Bethea, New Orleans, Medicine; Dr. Charles Reid Edwards, Baltimore, Surgery; Captain Walter S. Jensen, M. C., Randolph Field, Texas, Neuropsychiatry; Dr. Emil Novak, Baltimore, Gynecology; Dr. Otto Schwarz, St. Louis, Obstetrics.

AMERICAN MEDICAL GOLFERS PLAY IN KANSAS CITY, MONDAY, MAY 11

The American Medical Golfing Association will hold its twenty-second annual tournament at the Mission Hills Country Club and the Kansas City Country Club in Kansas City on Monday, May 11, 1936.

To accommodate comfortably the large entry which is anticipated, the Kansas City Committee has arranged play over two very fine courses which touch corners: the Mission Hills Country Club and the Kansas City Country Club. Their club houses are only one mile apart and ample transportation between the two has been arranged. Dinner for all players will be served in the Mission Hills Club House.

Seventy Trophies and Prizes

Thirty-six holes of golf will be played in competition for the seventy trophies and prizes in the nine events. Trophies will be awarded for the Association Championship, thirty-six holes gross, the Will Walter Trophy; the Association Handicap Championship, thirty-six holes net, the Detroit Trophy; the Championship Flight, first gross, thirty-six holes, the St. Louis Trophy; the Championship Flight, first net, thirty-six holes, the President's Trophy; the Eighteen-Hole Championship, the Golden State Trophy; the Eighteen-Hole Handicap Championship, the Ben Thomas Trophy; the Maturity Event, limited to Fellows over 60 years of age, the Minneapolis Trophy; the Oldguard Championship, limited to competition of past presidents, the Wendell Phillips Trophy; and the Kickers Handicap, the Wisconsin Trophy. Other events and prizes will be announced at the first tee.

Application for Membership

All male Fellows of the American Medical Association are eligible and cordially invited to become members of the A. M. G. A. Write the Executive Secretary, Bill Burns, 2020 Olds Tower, Lansing, Michigan, for an application

blank. Participants in the A. M. G. A. Tournament are required to furnish their home club handicap, signed by the secretary. No handicap over 30 is allowed, except in the Kickers' (Blind Bogey). Only active members of the A. M. G. A. may compete for prizes. No trophy is awarded a Fellow who is absent from the annual dinner.

The twenty-second tournament of the American Medical Golfing Association promises to be a happy affair. The officers anticipate that some two hundred medical golfers from all parts of the United States will play in Kansas City on May 11th.

REPORTS OF DISTRICT COUNCILORS*

FIRST DISTRICT—

W. C. Payne, M.D. .....*Pensacola*
Okaloosa, Walton, Santa Rosa, Escambia.

This district comprises the counties of Walton, Okaloosa, Santa Rosa, and Escambia. These counties are well organized, and all eligible men, with possibly one or two exceptions, are members of their county and state associations. Because of the small number of physicians in three of these counties, there are two counties to each society; Walton and Okaloosa form the Bi-County Medical Society, and the Escambia County Society also takes into membership physicians of Santa Rosa County. Both these societies meet regularly, and meetings are well attended.

Heretofore the discussions and activities of these societies have been limited to social and medical topics. During the last year, however, we have viewed with concern the gradual tendency toward state medicine and the encroachment of governmental agencies on private practice. We have been forced to realize that politically we have been impotent. With these things in view, a great part of the programs of the Escambia County Society during this year have been given over to a discussion of economic and political subjects. Interest in these subjects have been aroused to a great extent by the activities of Doctor H. L. Bryans, our State Association President, this being his home society. A political society has been formed in Escambia. The membership is composed of physicians, dentists, druggists and nurses. While this political organization is not officially affiliated with the Escambia County Medical Society, it was sponsored by the Escambia County Society. It is the purpose of this organization to look after the economic and political needs of its members. It is proposed to approach candidates for political office and ascertain their attitude toward our interests and to instruct them of our needs and desires. We believe we are pioneers in this movement in this state. We notice with gratification that other societies in this state are forming similar organizations.

It is obvious that if we organize on a statewide scale, that we can wield a political influence that cannot be ignored by political candidates and office holders.

I assure you that it has been a pleasure to serve my district as councilor.

*Read before the Pre-Convention Meeting, Jacksonville, February 23, 1936.

FOURTH DISTRICT—

William S. Manning, M.D. .....*Jacksonville*
Nassau, Clay, Duval, St. Johns.

The following is the report of the Fourth District of the Florida Medical Association. This district consists of four counties: Clay, Duval, Nassau and St. Johns. The only two component county societies are Duval and St. Johns. I am able to give at this time only the report of Duval County. I hope at a very early date to be able to send the report for St. Johns County. The Secretary of the St. Johns County Medical Society as yet has been unable to reply to my request for his report.

The report for Duval County is as follows:

1. At the beginning of the year 1935 there were 149 members on the roster; during the year the membership was increased by six which brought the membership to a total of 155, less two, one due to death and one due to transfer. This leaves a total at the end of the year of 153 members.

To date six members have been added to the society, the total now being 159, less one due to death, 158, as of February 20, 1936.

2. During the year 1935 there were 8 members who did not pay their dues. Computing on the basis of 155 members, the percentage of dues paid during 1935 was 94.9 per cent.

Sixty members have paid their dues for 1936, therefore the percentage paid to date is 38 per cent.

3. The number of members from other counties and states is four.

The Duval County Medical Society acted as host for the Southeastern Surgical Congress

March 11, 12, and 13, 1935. This was one of the most successful and enjoyable meetings ever held by this Association.

SEVENTH DISTRICT—
WALTER C. PAGE, M.D. .....*Cocoa*
Brevard, Volusia, Seminole.

I have the honor to render this report as councilor of the Seventh District.

The Seventh Councilor District is composed of the Counties of Brevard, Seminole and Volusia. In this district there are approximately seventy-two physicians of which sixty or about eighty-five per cent are members of their respective physicians in this district.

county societies; there also are three colored

Each County Society has held eight meetings during the past year, all of them suspending their meetings during the months of June, July, August and September. It also is the custom of all three societies to hold their monthly meetings after a luncheon or dinner. The average attendance at these meetings was from sixty to eighty per cent of the membership.

TENTH DISTRICT—
R. L. CLINE, M.D. .....*Lakeland*
Polk.

We have a friendly, active county medical society with a membership of sixty. One hundred per cent paid last year; to date 33 1/3% have paid. Every eligible doctor in the county is a member, save two, and I am working on them. We meet bi-weekly around the dinner table in the evening with an average of approximately 60% to 70% present. Usually we have a scientific program. At our meeting on February 12, 1936, our President, Dr. S. A. Clark, appointed a Legislative Committee, the function of that Committee being to contact candidates in the race for the Senate and House, and to secure from each of them a promise to work for legislation favorable to our profession. In the past we have failed to have favorable laws enacted, and that failure has been due to the fact that we have not been successful in getting the profession interested in the candidate before the election. So, if we can at this time get the profession interested before the election, we will succeed.

THIRTEENTH DISTRICT—
R. R. DUKE, M.D. .....*Tampa*
Hillsboro.

Hillsboro County Medical Society has enjoyed a very satisfactory year. Fifteen new members have been admitted to the Society and there has been one transfer. Apparently some of the new members are very excellent men and we feel that they will be quite an addition to the Society. It is with much regret on the part of the entire Society that we have lost, by death, two of our most prominent members. I refer to Dr. Earl H. McRae, who was one of our past presidents, and to Dr. Bundy Allen, who was a past president of the American Radiological Society. Our membership consists of one hundred fourteen, with only four unpaid dues.

The scientific programs have been very well supported. On two occasions the programs have consisted of symposiums on tuberculosis and obstetrics. It was our pleasure and good fortune to have at one meeting Dr. Willis Campbell, who gave an address on the subject of "Ununited Fractures." His paper was wonderful and was enjoyed by all. We were also honored with an address by the oldest and only honorary member of the Society, Dr. L. S. Oppenheimer, who spoke on the subject of "How to Live Longer Usefully." The December program was put on in St. Petersburg, where we were the guests of the Pinellas County Medical Society.

We are very fortunate to have some nationally known men to address the Hillsboro County Society this year. On February the fourth we had Dr. A. B. Craddock and Dr. J. A. Moore of Asheville, N. C. On February the twenty-fourth we will have Dr. James S. McLester, president of the American Medical Association, and Dr. Herbert Bryans, president of the Florida Medical Association. On March the third we will have Dr. W. D. Lower, of the Cleveland Clinic, and on March the thirty-first, Dr. J. A. Bargen, of the Mayo Clinic.

St. Joseph's Hospital has been in operation a little more than a year. It is an excellent institution and seems to be doing very well.

At our last meeting an Inter-relationship Committee was appointed. This committee is to meet with a like committee from the Pharmacists and Dentists, to create an Allied Political Health Council to discuss and act on matters of common interest to all.

FOURTEENTH DISTRICT—
D. A. MCKINNON, M.D. .....*Marianna*
Calhoun, Jackson, Gulf.

The Jackson County Medical Society meets the second Tuesday of each month at the Chipola Hotel at seven thirty. At these meetings there

is either a scientific paper read or round table talks.

All the doctors from Calhoun County are members of the Jackson County Medical Society. The doctors from Washington County have been invited to join with Jackson County. In spite of their apparent willingness for such an arrangement, so far have been unable to get them over for a meeting. Bay County is apparently taking more interest in their local society and plans have been discussed for a joint meeting with Jackson some time in the near future.

SIXTEENTH DISTRICT—
W. L. Ashton, M.D. ..... *Umatilla*
Sumter, Lake.

The Sixteenth District, comprising Sumter and Lake County Medical Societies, continues to function creditably. Regular meetings of both county society units are well attended, and joint meetings are frequently held.

The membership roster of the Sumter County Society numbering but four, remains unchanged; however, several other physicians reside in this County and hold membership in adjacent County Societies by reason of accessibility.

Lake County Medical Society is well organized and its roster of nineteen includes all the eligible practitioners in the County. Programs of scientific interest are stressed, and guest speakers at frequent intervals are a stimulus to well attended luncheon meetings.

One member was lost during the past year by resignation due to ill health, and another member gained by transfer from an adjacent County Society.

The Hospital at Umatilla sponsored and operated by the Lake County Medical Society celebrated its third birthday on February 20th. It would appear that this institution has been a means of promoting increased harmony and fostering a keener interest in medicine and surgery in the profession utilizing it, besides having supplied a real and needed service to the County and adjacent communities as evidenced by its rapid expansion from an initial fifteen beds to its present capacity of forty.

The officers of the Society for the year, 1936, elected at the December meeting are: President, Dr. R. H. Williams, Eustis; Vice-President, Dr. L. H. Oetjen, Leesburg; Secretary and Treasurer, Dr. W. L. Ashton, Umatilla.

SEVENTEENTH DISTRICT—
Louis Orr, M.D. ..... *Orlando*
Osceola, Orange.

The Seventeenth District of the Medical Association of Florida is composed of the counties of Orange and Osceola with the Orange County Medical Society as its single medical organization. The past year has seen much activity within the society and the addition of five new members, making a total of fifty-eight.

Orlando and the Orange County Society acted as hosts for the Pre-Convention meeting of 1935, the closing event of which was a buffet supper tendered by the Society at the University Club.

The greatest activity in the district during the past year has centered around the legislative committee. Every state legislator and congressman was contacted in regard to medical legislative problems and every effort was expended to defeat legislation unfavorable to organized medicine. Almost every society member sent personal letters to Washington in protest against the Wagner-Epstein Bill.

The Society has used every means to suppress the seasonal influx and operation of the various diet faddists, charlatans and other forms of quackery which annually overrun the community.

The summer picnic was held at Lakeside Park on July 27th and more than one hundred visiting physicians attended. The picnic is to be an annual affair and it is hoped that the number of visitors will in time increase.

On September 14, 1935, the Society lost, by death, its oldest honorary member, Dr. W. C. Persons, one of six surviving Confederate soldiers of Orange County. Always a strong supporter of ethical, organized medicine, his loss will be keenly felt.

After many years of controversy with the Parent-Teachers' Association regarding the examination of school children the society finally enacted into the by-laws a clause declaring that those children able to pay for medical care should be examined by their family physician and that those found unable to pay, after investigation by the Welfare agencies, would be examined by the various physicians without charge.

The Florida Public Health Association met in Orlando on December 2nd, 3rd and 4th and a large number of the Society members attended and many assisted in entertaining the members.

The radio broadcasting of medical topics, from station WDBO still continues under the able chairmanship of Dr. Henry Spiers. Experience

has shown that these broadcasts are valued highly by the laity and it is the intention of the society that they be continued as it is felt that they represent a real contribution toward the medical education of the public.

EIGHTEENTH DISTRICT—
H. GATES, M.D.....*Bradenton*
Manatee, Sarasota.

I wish to make the following report:

Manatee County and Sarasota County Medical Societies have been holding their regular meetings at Whitfield Country Club. The societies alternate in presiding over the meetings and furnishing the programs. The papers this year have been unusually interesting. At different intervals Hillsboro County Society has furnished and read us their papers, and seemed to be glad to give us the benefit of their knowledge. As a whole this had been a good year in our District. The members have cooperated nicely with the different officers and committees and have tried to do their part.

(No reports from Councilor Districts Nos. 2, 3, 5, 6, 8, 9, 11, 12, 15, 19, 20, 21.)

STATE NEWS ITEMS

Dr. J. Maxey Dell of Gainesville was recently appointed Superintendent of the Florida Farm Colony for the Feeble Minded to succeed the late Dr. J. H. Colson.

* * *

Dr. Shaler Richardson, Jacksonville, was recently appointed to membership on the Florida State Board of Health to succeed the late Dr. Harry Dash Johnson.

* * *

The Allied Council for Health Legislation, Pinellas County Unit, mailed postal cards to all physicians, dentists, nurses and pharmacists in St. Petersburg urging them to register during the month of March. The postal card also urges the payment of poll tax and the voting for candidates favorable to the regular professions. This activity of the new Allied Council should bring good results.

* * *

Dr. James Henry Colson of Gainesville died March 6, 1936. Dr. Colson was appointed Superintendent of the Florida Farm Colony at Gainesville in 1928 and previously served as physician at the Prison Farm at Raiford. He was also at one time Senator from Alachua County.

Dr. Howard Fox was recently a guest of Dr. J. L. Kirby-Smith of Jacksonville. Dr. Fox is Professor of Dermatology, New York University and Bellevue Medical College.

SAMUEL HOLT TOY

Dr. Samuel Holt Toy of Umatilla died February 24, 1936, at the age of 85 years. Dr. Toy practiced medicine at Umatilla for fifteen years. He was born in Robards, Kentucky.

Dr. Toy began the practice of his profession at Robards, Kentucky, and later practiced for a number of years in Tennessee. Fifteen years ago, Dr. Toy came to Umatilla from Tennessee and established himself in his profession. He was a loyal member of the Methodist Church and the Masonic Lodge and a member of the Lake County Medical Society, the Florida Medical Association and the American Medical Association.

Dr. Toy is survived by his widow, Mrs. Emily Toy, and one son, W. E. Toy of Detroit, Mich.

Very favorable reports have been received of the symposium on "Medical Economics" which is being presented to the public in the form of radio broadcasts over Station WRUF by our Committee on Public Relations. One phase of medical economics has been broadcast each Sunday evening at 6:00 o'clock since the inception of the series, on March 1. To date the following topics have been covered: "Introduction to Medical Economics," "Cost of Medical Education', "Medical Relation to Workmen's Compensation," "Health Insurance," "Defects in Medical Insurance," "Contract Practice." The schedule for the next four weeks is as follows:

8. April 19—Plans for Payment of Medical Care—W. H. Spiers, Orlando.

9. April 26—Health Insurance in England—Edward Jelks, Jacksonville.

10. May 3—Health Insurance in Various Parts of the World—T. M. Palmer, Jaksonville.

11. May 10—A Synopsis and Critical Analysis of Sik Insurane and Cost of Medical Care—J. Ralston Wells, Daytona Beach.

* * *

The following members of our Association attended the meeting of the Southeastern Surgical Congress at New Orleans: Drs. M. A. Lischkoff and Carol C. Webb, Pensacola.

Dr. Paul K. Jenkins of Miami Beach announces the removal of his office to the Lincoln Medical Building, 541 Lincoln Road.

* * *

Dr. Louis M. Orr, II, of Orlando announces the association of Dr. Doran T. Rue.

* * *

Dr. Kenneth Phillips of Miami, by invitation presented a paper on "Hyperpyrexia In Bronchial Asthma" at the Fever Symposium of Southern Section American Congress Physical Therapy, New Orleans, Louisiana, March 23, 1936.

* * *

Dr. L. M. Anderson of Lake City, on March 18, 1936, completed fifty years of practice of medicine in Florida. Doctor Anderson has been a member of the Florida Medical Association for forty years. He is a past president of the Association and has been chairman of practically every committee at one time or another. He holds the honor of being the first life member elected by the Association.

* * *

The following quotation is from Dr. L. M. Anderson's presidential address, published in the June, 1923, Journal of the Florida Medical Association:

"We must play a more prominent role in legislation, not only of local but of State and National character, affecting the health of our people; and while ours is a non-political organization, yet more physicians should be numbered among our legislators and congressmen to guide legislation pertaining to the public health.

"Governor Smith, of New York, on the 26th of February of this year, set a precedent which, if followed consistently, promises much good along these lines. Calling together a number of the members of the New York Medical Society, he requested their advice and constructive recommendations as to needful measures along health lines for presentation to the legislature.

"Our own Governor Hardee has during his administration conferred with members of this Association, seeking their counsel in matters and measures proposed pertaining to public health. His policy along this line has been most commendable and broadminded.

"I would like, at this time, to say a few words concerning our own association. It is and will ever continue to be just what, as members, we make it. The county medical society is the unit and foundation upon which all other medical societies are based. Its ideals should be of the highest and the membership make its influence a potent factor in the health administration of the county."

"Much advancement in public hygiene and sanitation throughout Florida is directly traceable to this association. Our State Board of Health, founded in 1889 (and there is none better), was badly crippled as a result of the false economy practiced by our last legislature in cutting the appropriation, and at a time when funds were most vitally needed. It is to be hoped that this legislature will appreciate the vision and sufficiently endow our Board of Health with funds that it may carry out its program, untrammelled during the ensuing two years. It might not be amiss for us as a body to petition our legislators to carefully consider the needs of this great agency, safeguarding the health and lives of the people of our commonwealth."

* * *

The P. & O. Steamship Company will open an office in the McAllister Hotel, Miami, Sunday, April 26. Doctors may purchase their tickets at the McAllister Hotel and fill out papers for landing at Havana. All doctors who arrive Sunday are requested to visit the P. & O. office at the McAllister Hotel and make arrangements for purchasing tickets and filling out their papers.

Those who drive to Miami may leave their cars at the P. & O. docks and the cars will be taken care of during the meeting and returned to the docks Wednesday noon. There will be a nominal charge for garage rent but the P. & O. Steamship Company will look after the cars during the absence of doctors and their guests.

* * *

Drs. W. McL. Shaw and J. G. Lyerly of Jacksonville were guests at the March meeting of the Eighth District Medical Society at Waycross, Georgia. They presented interesting papers dealing with "The Diagnosis and Treatment of Brain Tumors." The Eighth District Medical Society draws from a large territory and is very active. The Jacksonville guests were treated royally and enjoyed the fellowship of the large gathering of doctors.

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COMPONENT COUNTY SOCIETIES

BAY COUNTY MEDICAL SOCIETY

Some more news from Bay County Medical Society. Thursday night, March 5th, Dr. Herbert L. Bryans was guest speaker and gave a wonderful address on "Medical Economics with the Trend of Medical Practice in Our State." Dr. W. C. Payne of Pensacola gave a very instructive and educational talk on "Infections of the Cervix". Dr. Julius Davis of Quincy gave a few highlights on medical legislation. Among the guests at this meeting were the following doctors from Pensacola: Drs. Payne, Bryans, Fellows, White, McLane, Lischkoff, Quina, McSween and Lieut. Commander Branan, U. S. N. Medical Corps. From Quincy: Drs. Davis and Griffith. From Marianna: Drs. McKinnon, Chappell, Whitaker. From Dothan, Ala.: Drs. Roberts, Ellis, Latiolais and Turner.

This was a very enjoyable meeting and the Society is anxious to let the rest of the State know that they are doing their best for organized and scientific medicine.

DADE COUNTY MEDICAL SOCIETY

In place of the regular March monthly meeting, a called meeting was held February 26th to honor the president of the American Medical Association, Dr. James S. McLester. Other prominent guests at the meeting were Dr. Herbert L. Bryans, Pensacola, president of the Florida Medical Association and Dr. Julius C. Davis, Quincy. Doctor McLester spoke on "The Attitude of the American Medical Association towards Socialized Medicine", and "Borderline States of Nutritional Failure." President Bryans presented "Future Trend of Medicine in Florida" and Doctor Davis made a brief address on the political situation as it concerns the medical profession.

LAKE COUNTY MEDICAL SOCIETY

At a meeting of the Lake County Medical Society held on March 5, Dr. T. M. Palmer of Jacksonville was guest speaker. He presented an interesting paper on "Diagnosis of Tuberculosis with Reference to the Tuberculin Test."

LEE COUNTY MEDICAL SOCIETY

THE LEE COUNTY MEDICAL SOCIETY HAS JUST REPORTED 100% OF MEMBERSHIP DUES PAID FOR 1936.

MADISON COUNTY MEDICAL SOCIETY

THE MADISON COUNTY MEDICAL SOCIETY HAS JUST REPORTED 100% OF MEMBERSHIP DUES PAID FOR 1936.

MANATEE COUNTY MEDICAL SOCIETY

The Manatee County Medical Society is this year headed by the following officers:

President—Samuel G. Hollingsworth, Bradenton.

Vice-President—C. W. Larrabee, Bradenton.

Sec'y-Treas.—M. M. Harrison, Bradenton.

MONROE COUNTY MEDICAL SOCIETY

THE MONROE COUNTY MEDICAL SOCIETY HAS REPORTED 100% OF DUES PAID FOR 1936. THE OFFICERS OF THIS SOCIETY ARE:

President—H. C. GALEY, KEY WEST.

Vice-Pres.—N. C. PINTADO, KEY WEST.

Sec'y-Treas.—WILLIAM R. WARREN, KEY WEST.

PASCO-HERNANDO-CITRUS COUNTY MEDICAL SOCIETY

Dr. J. T. Bradshaw of San Antonio was host to the members of the Pasco-Hernando-Citrus County Medical Society at the Gray Moss Inn in Dade City on Thursday evening, March 12. Dinner was served, after which the business and scientific meeting was held. Dr. F. T. Furlow, formerly of Brooksville, now of St. Louis, gave a very interesting talk on "Head Injuries."

Those present were: Dr. R. D. Sistrunk, Dr. Geo. R. Creekmore, Dr. S. C. Harvard, Dr. W. H. Cox, Dr. J. T. Bradshaw, Dr. J. J. Bourke and Dr. A. B. Cannon.

PINELLAS COUNTY MEDICAL SOCIETY

The regular bi-monthly meeting of the Pinellas County Medical Society was held March 20, 1936, at 6:30 p. m., at the St. Petersburg Shrine Club. Dr. C. O. Anderson presented a paper on "Spinal Anesthesia" and Dr. W. A. McPhaul, State Health Officer, addressed the gathering as an invited guest speaker. The meeting was well attended and a very pleasant social hour enjoyed by all before the gathering dispersed.

Future meetings of the Pinellas County Med-

ical Society will be dinner meetings on the first and third Fridays of each month at 6:30 p. m. All meetings will be held at the Shrine Club.

PUTNAM COUNTY MEDICAL SOCIETY

THE PUTNAM COUNTY MEDICAL SOCIETY IS THE FOURTH SOCIETY TO REPORT 100% OF DUES PAID FOR 1936.

ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY

The St. Lucie-Okeechobee-Indian River-Martin County Medical Society is this year headed by the following officers:

President—M. D. Council, Ft. Pierce.
Secretary—G. C. Hardie, Ft. Pierce.
Delegate—E. B. Hardee, Vero Beach.

SEMINOLE COUNTY MEDICAL SOCIETY

THE SEMINOLE COUNTY MEDICAL SOCIETY IS THE THIRD SOCIETY TO REPORT 100% OF DUES PAID FOR 1936. OFFICERS OF THIS SOCIETY ARE:

President—J. T. DENTON, SANFORD.
Vice-Pres.—H. D. SMITH, SANFORD.
Sec'y-Treas.—DOUGLAS G. SCOTT, SANFORD.
Delegate—W. T. LANGLEY, SANFORD.
Alternate—A. W. KNOX, SANFORD.

SUMTER COUNTY MEDICAL SOCIETY

THE SUMTER COUNTY MEDICAL SOCIETY HAS JUST REPORTED 100% OF MEMBERSHIP DUES PAID FOR 1936. THE OFFICERS OF THIS SOCIETY ARE:

President—A. B. ALBRITTON, WILDWOOD.
Secretary—W. E. MITCHELL, BUSHNELL.
Delegate—S. C. WOOD, LEESBURG.

TAYLOR COUNTY MEDICAL SOCIETY

The Taylor County Medical Society is this year headed by the following officers:

President—J. C. Ellis, Perry.
Vice-Pres.—G. H. Warren, Perry.
Sec'y-Treas.—J. L. Weeks, Perry.
Delegate—Ralph J. Greene, Perry.
Alternate—W. J. Baker, Foley.

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MRS. L. C. INGRAM, Finance . . . . . *Orlando*
MRS. S. M. COPELAND, Press and Publicity . . . . *Jacksonville*

Auxiliary News

Mrs. Rogers N. Herbert, President, requests that an announcement be made of the annual meeting of the American Medical Auxiliary to be held in Kansas City, May 11-15, with the Hotel Baltimore as headquarters. Plans are going forward rapidly to make the convention one of unforgettable inspiration, and alternates, delegates or others planning to stay at the Hotel Baltimore, should make reservations immediately by writing the management.

Mrs. Herbert says: "I hope that it will be possible for every president-elect to attend, as well as every president, since experience has shown that presidents-elect are fitted for a better administration as a result of the education and inspiration of a great national meeting. A cordial invitation to the convention is extended to every Auxiliary member, whether or not she holds any official position in the work."

Duval County Auxiliary

The Duval County Medical Auxiliary met Thursday, March 5, in the home of Mrs. Horace Drew on West Third Street. In the absence of the president, Mrs. J. H. Owens, vice-president, presided.

Mrs. Gordon H. Ira and Mrs. S. M. Copeland were elected delegates to the State Medical Convention to be held in April. Mrs. Edward Jelks and Mrs. J. W. Hayes were elected alternates. Mrs. E. W. Veal introduced Dr. Gerry R. Holden, guest speaker, who is chairman of the Cancer Control committee of the State Medical Association.

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Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245★
N. Y. State Jour. Med. 1935, 35—No. 11,590
Laryngoscope 1935 XLV, 149-154

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Dr. Holden made a report on behalf of his committee. He stated that they were working in collaboration with the American Society for the Control of Cancer, which has been of great assistance in many ways; supplying literature, lantern slides and films, projectoscopes and various other material which has been most valuable. The activities of this committee are purely educational. It endeavors to bring to the public reliable information regarding the early symptoms of cancer so that people can properly protect themselves in the stage when cancer is curable. It also brings to the various County Medical Societies throughout the State the latest developments regarding the diagnosis and treatment of cancer.

Dr. Holden expressed the great appreciation of his committee for the assistance which had been rendered it by the various auxiliaries throughout the State and said that without this assistance the program for the laity could never have been put forth as fully as it had been. He presented some facts about cancer as a problem of public health, stressing the point that the increased mortality of cancer, as indicated in the United States Public Health report, did not necessarily mean that the individual cases were actually increasing in number. He said that this increased death rate was accounted for in great part, at least, by improvement in collecting statistics and increasing skill on the part of the doctors in diagnosing the disease. The basis upon which cancer control was resting was then outlined; the fact that cancer in its earliest stage is a curable disease and therefore it is necessary for the patient to recognize the symptoms early and obtain satisfactory treatment early.

He stated that one of the greatest factors in preventing patients from seeking medical advice was the antiquated idea that "no cancer is ever cured." This of course is erroneous. He concluded his talk by showing a series of films, supplied by the American Society for the Control of Cancer, which illustrated various points regarding cancer control.

Following the address Mrs. Drew assisted by her sister, Mrs. Turner Butler, served refreshments. About twenty-five members and guests were present.

Orange County Auxiliary

The Woman's Auxiliary to the Orange County Medical Society held its monthly luncheon



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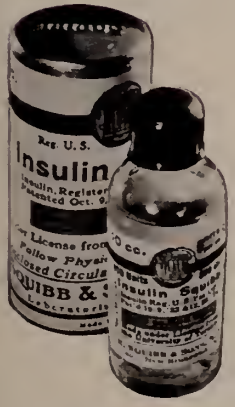
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March 3, at the Perrydell. The guest speaker was Dr. W. H. Spires, a member of the Public Relations committee of the Florida Medical Association.

During the brief business meeting which followed the luncheon Mrs. L. C. Ingram, president of the Auxiliary, appointed a nominating committee for the annual election of officers. The committee includes Mrs. Frank Gray, chairman; Mrs. Sam Ricker and Mrs. Claude Anderson. Due to illness only eight members were present.

Pinellas County Auxiliary

The Woman's Auxiliary to the Pinellas County Medical Society held their regular monthly luncheon and business meeting at the Yacht Club March 16, and was attended by nineteen members and guests.

Arrangements were made for a tea to be given at the Crittenden Home March 25; hostesses, Mesdames William Farber, C. O. Anderson, A. R. Frederick, Prescott Le Breton, Thad S. Troy, O. O. Feaster, C. Wright and Raymond Keith O'Brien. During the social hour Miss Engelshall played two violin selections and accompanied Mrs. O'Brien who sang "Mother Machree." The next meeting will be in the form of a beach party at which time it is hoped to have the opportunity of entertaining some out of town Auxiliary members.

The January meeting of the Pinellas Medical Auxiliary was held at the Yacht Club. The members voted to support the Community Chest drive and to try to raise some money for the purpose of placing Hygeia in the Public Schools.

Miss Lois Faber, secretary of the Y. W. C. A., spoke on the human side of the work done by that organization. Dr. W. C. McConnell talked on different forms of psychoses. The Auxiliary sponsored a Dinner Dance in December which was attended by sixty members and guests.

ADVERTISERS' NOTES

The Treatment of Angina Pectoris

The treatment of angina pectoris has been very ably discussed by Dr. N. C. Gilbert of St. Luke's Hospital, Chicago, in the Medical Clinics of North America for January, 1936.



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Gilbert believes that an attack of angina pectoris occurs whenever the metabolic needs of the heart muscle are increased out of proportion to the blood supply available at the moment. Such attacks may be brought on by exertion, indigestion and emotional upsets; attacks may also occur in patients with pernicious anemia due to an insufficient supply of oxygen for the heart muscle or in patients with diabetes following temporary hypoglycemia after insulin; in some patients the attacks can only be ascribed to an over-labile autonomic nervous system. A great deal of the patient's future depends on what the physician says. The physician should try to gain a common ground of understanding with the patient, to encourage him and at the same time evaluate the factors which predispose to the attack and direct the patient as to how the attacks can best be avoided.

The attacks themselves are best relieved by amyl nitrite or nitroglycerine. Between attacks, most cases can be materially helped by medication with the purine base diuretics (theobromine and theophylline salts). In order not to discourage the patient with untoward effects treatment is started with theobromine-calcium salicylate (Theocalcin) which only very rarely causes distress. It is assumed that tolerance to its purines is acquired and Theocalcin medication is alternated with theophylline ethylenediamine or theophylline-calcium salicylate (Phyllicin), which is quite as effective clinically. Theocalcin is given in 7½ grain tablets, 1 or 2 at a time and Phyllicin in 4-grain tablets. All the purine salts are best taken during the meal. Rest from medication may be allowed for a few days each week.

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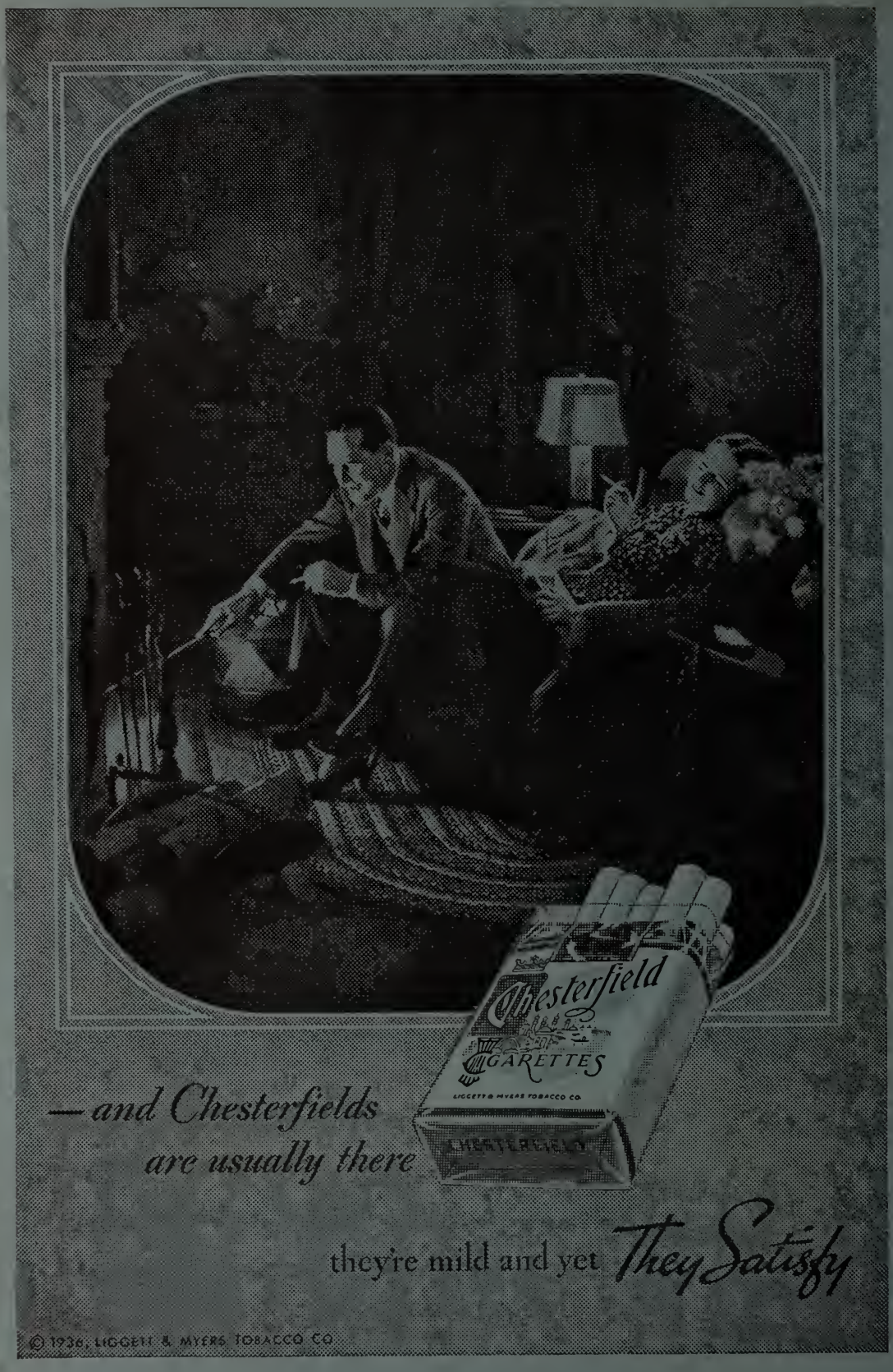
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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	J. E. Maines, Jr., M.D., 331½ W. University Ave., Gainesville	H. M. Merchant, M.D. 124 E. University Ave., Gainesville	2nd Friday 7:30 P.M.	Primrose Gfill Gainesville	22	85%
Bay	W. C. Roberts, M.D., Panama City	Allen H. Miller, M.D., Millville			8	62%
Brevard	I. F. Bean, M.D., Melbourne	Bob Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies	3	30%
Broward	Elliott M. Hendricks, M.D., 314 Sweet Building, Fort Lauderdale	R. E. Blount, M.D., 360 S. E. 26th Ave., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Landerdale	24	100%
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	9	90%
Dade	John E. Hall, M.D., Box 2722, Miami	M. E. Threlkeld, M.D., Congress Bldg., Miami	1st Friday 8:30 P.M.	Club Rooms Huntington Bldg., Miami	191	86%
DeSoto-Hardee-Highlands	C. H. Kirkpatrick, M.D., P.O. Box 454 Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies	6	30%
Duval	W. M. Shaw, M.D., St. James Bldg., Jacksonville	H. W. Porter, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	119	81%
Escambia	A. M. Ames, M.D. Blount Bldg. Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola	22	54%
Hillsboro	William C. Blake, M.D., 412 Citizens Bank Bldg. Tampa	James S. Grable, M.D., 822 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa	101	87%
Jackson	C. D. Whitaker, M.D., Dekle Bldg. Marianna	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna	8	62%
Lake	R. H. Williams, M.D., Eustis	W. L. Ashton, M.D., Umatilla	1st Thursday 12:30 PM.	Eustis	13	100%
Lee	William H. Grace, M.D., 15 Earnhardt Bldg., Fort Myers	H. Quillian Jones, M.D. 18-20 Leon Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers	10	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	R. F. Godard, M.D., Key Building, Quincy	B. A. Wilkinson, M.D., Telephone Bldg., Tallahassee	Quarterly 3:00 P.M.	Varies	20	53%
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison			3	100%
Manatee	S. G. Hollingsworth, M. D. 451 12th. St. Bradenton	M. M. Harrison, M.D. Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Club Bradenton	11	85%
Marion	J. N. Moore, M.D., 210-12 Professional Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala	22	100%
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies	4	100%
Orange	William E. Sinclair, M. D. Clinic Bldg. Orlando	J. A. Pines, M.D., 106-10 E. Central Ave., Orlando	3rd Wednesday 8:30 P.M.	Varies	52	91%
Palm Beach	L. McK. Rozier, M.D., 411 Comeau Bldg., West Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach	50	91%
Pasco-Hernando-Citrus	R. D. Sistrunk, M.D., Dade City	John J. Bourke, M.D., Dade City	2nd Thursday 7:00 P.M.	Varies	8	52%
Pinellas	F. E. Kauffman, M.D., Coachman Bldg., Clearwater	W. C. McConnell, M. D. 1005 Equitable Bldg. St. Petersburg	1st. and 3rd. Friday 6:30 P.M.	Shrine Club St. Petersburg	79	98%
Polk	R. L. Hughes, M.D., 225 E. Main St., Bartow	J. R. Boulware, Jr., M.D., P. O. Box 367, Lakeland	2nd Wednesday in Feb., April, June, Aug., Oct., Dec. 1:00 P.M.	Lakeland	31	53%
Putnam	Allen P. Gurganeous, M. D. Palatka	A. E. Drexel, M.D., Palatka	2nd Thursday 7:00 P.M.	James Hotel, Palatka	9	100%
St. Johns	Herbert E. White, M.D., 401 First Natl. Bank Bldg St. Augustine	R. D. Harris, M.D., St. Augustine	3rd Tuesday 8:30 P.M.	Varies	9	90%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., P. O. Box 942, Stuart	E. B. Hardee, M.D., Vero Beach	3rd Thursday 8:00 P.M.	Varies	8	67%
Sarasota	C. B. Wilson, M.D., 1st B. & Tr. Bldg., Sarasota	J. E. Harris, M.D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P.M.	Varies	15	94%
Seminole	J. T. Denton, M.D., Meisch Bldg. Sanford	Douglass G. Scott, M. D. Box 489 Sanford	2nd Monday 7:00 P.M.	City Hospital Sanford	12	100%
Sumter	A. B. Albritton, M.D., Wildwood	W. E. Mitchell, M.D., Box 237 Coleman	2nd Tuesday	Varies	4	100%
Taylor	W. J. Baker, M.D., Foley	C. A. O'Quinn, M.D., Perry	Last Friday 8:00 P.M.	Dixie-Taylor Hotel, Perry	5	83%
Volusia	H. W. Henry, M.D., 205 State Bank Bldg., New Smyrna	W. C. Chowning, M. D. 111 Palmetto St. New Smyrna	2nd Tuesday 7:30 P.M.	Varies	34	87%
Walton-Okaloosa	R. B. Spires, M.D., DeFuniak Springs	A. G. Williams, M.D., Lakewood	3rd Thursday 8:00 P.M.	Varies	6	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



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THE JOURNAL
—— OF THE ——
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Southern Medical Association, Baltimore, Md., November 17-20, 1936.

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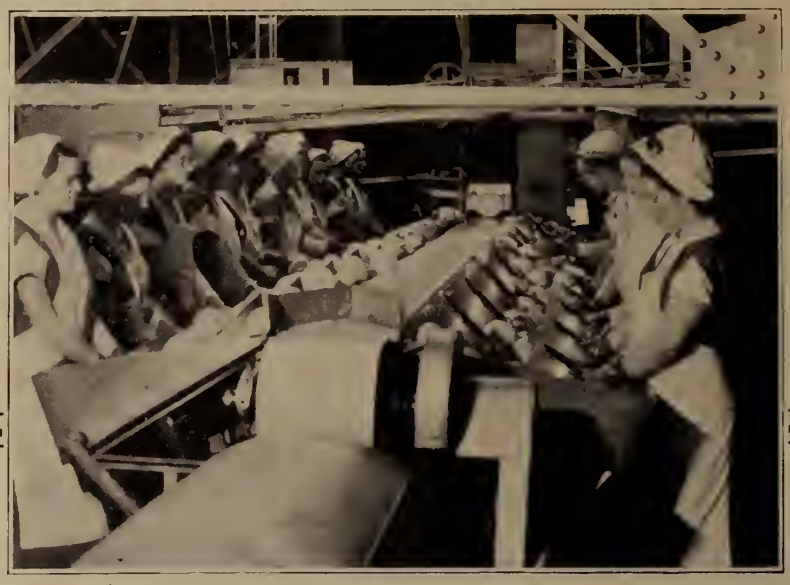
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*Martenstein, H.: Syhilis Treatment: Enquiry in Five Countries, *League of Nations Quart. Bull. Health Organ*, 4: 129, 1935.



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Karo	2 tablespoons
Lactic Acid Milk	12 ounces
Boiled Water	8 ounces
Karo	2 tablespoons

REFERENCES:

Kugelmass, Clinical Nutrition in Infancy and Childhood, Lippincott.
Marriott, Infant Nutrition, Mosby.
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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION
PUBLISHED MONTHLY

Volume XXII | Jacksonville, Florida, May, 1936 | Number 11

President's Address*

HERBERT L. BRYANS, M.D.,
Pensacola.

For the past year I have enjoyed the privilege of serving the Florida Medical Association as its President and I wish to again express my deep appreciation of this honor.

The duties of your President entail the expenditure of time and effort, and if in even a small measure our united activities during the past year are productive of progress in advancing the cause of organized medicine during this uncertain age these will have been well invested. It has been a privilege as well as a real pleasure to be associated with so many enthusiastic workers on the various committees who have formulated the policies of our State Association. The depression has produced so many agencies that seek to change the existing order of things, that it has been necessary for more Committee meetings this year than usual.

We have listened so long to the echoes of various social theories as enunciated by the New Dealers in a true or erroneous interpretation of present social needs and their remedies that we, as Doctors of Medicine, familiar with the would-be panaceas of quackery, might wonder if the alphabetical method of designating these multifarious social remedies derived its origin from such medical prototypes as X. Y. Z.

The practice of medicine imposes an obligation on doctor as well as patient. The services of the modern progressive doctor are of the highest quality according to recognized standards of medical science, and the patient should reward the doctor for his services according to the recognized standards of economics in his community.

This high standard of scientific medicine requires individual professional services to individual patients. This personal relationship must be preserved whether the system be that of private practice or State Medicine. Until the time comes when human beings shall have been standardized, mass plans for medical care must of necessity tend to lower the quality of individual medical service, and unit medical care must be judged only on the basis of the quality of service rendered.

A Detroit physician stated: "If I want to give away my money, I should be the person who will dictate where that money is going; but if I want to give away my time in a dispensary, I find myself the only person who has absolutely nothing to say about it. That is why I'm now dispensing my charity service in my office and not in a so-called free clinic."

Let me emphasize the importance of each practicing physician continuing to donate his share of charity work in his own office and in the homes of his deserving clientele as in years gone by. Let no deserving patient turn away and state that he was denied individual medical service. There are certain charity cases that the community or other agencies should and must assume responsibility for, but I refer only to those cases known to you as deserving and unable to obtain relief through other sources.

If such cases are continually refused medical services by physicians of their own choice they will then seek the clinic where services will be rendered on the industrial pattern of mass turnover with its standardized type of medical service. If a sufficient number of patients over a period of time become habituated into seeking such medical services, it will mold public opinion against that efficient private or individual service.

An intensive and continuous educational campaign in time must convince the public not to require the physician to donate his services and at the same time pay in taxes his share of the

*Delivered before the Sixty-third Annual Meeting of the Florida Medical Association held aboard the SS. "Florida", April 27, 28, and 29, 1936.

cost of sickness among the indigent. Remuneration for medical services should be added to all other expenses connected with sickness among this class of individuals and the total cost of medical care equally underwritten by all taxpayers.

Just a thought on the high cost of medical care. Dr. Morris Fishbein states that a commission on medical education, after seven years of study, came to the conclusion that about eighty-five to ninety per cent of all diseases for which people consult doctors can be competently diagnosed and treated by a general practitioner with the equipment carried in his handbag or available in his office. The remaining ten or fifteen per cent represent serious diseases which require study and treatment in a hospital. Therefore, it is not the usual run of illnesses that financially tax the middle class beyond its income. When hospitalization becomes necessary, room charges, laboratory, x-ray and nursing fees begin to mount and the cost of sickness abruptly soars. In other words, only about ten per cent of the patient population are cared for in hospitals in any one year and yet hospitalized illnesses consume fifty per cent of the total annual expenditures for all medical care.

A patient is admitted to a hospital for cholecystectomy, develops complications and requires two weeks for convalescence. An average private room costs $84.00, operating room $10.00, laboratory $5.00, drugs and dressings $10.00, two nurses for two weeks $168.00; hospital and nursing charges total $277.00. Suppose the surgeon charges $150.00 and a consultant $50.00. There is a grand total of $477.00. Comparatively few people can promptly pay these bills. The doctor is only one-third of the cost and usually the last third to be paid. If these charges continue to mount, the physician must eventually evolve some other type of service to meet the needs of his patients. Supervised group hospitalization on the insurance plan will probably help in solving this situation. This plan is spreading rapidly among the hospitals throughout the United States. Your Hospital Committee will cover this subject in their report as related to hospitals in Florida. Such a plan for hospitals would certainly encourage prompter settlement of medical bills and reduce the cost of hospitalization to its participants.

Conditions have changed so rapidly during the last few years that we find some who are out of line with our present code of ethics. I would recommend creating a permanent Medical Ethics Committee in this Association, which will consider and approve for adoption a professional and economic code for our guidance and also render assistance and advice in the settlement of county society ethical problems.

State Public Health Officer, Dr. W. A. McPhaul, has assured me that he desires to cooperate with organized medicine of this state. He has requested that a State Medical Association Advisory Committee to the State Board of Health be appointed. Your executive committee has authorized the appointment of such a committee, the personnel of which has been held in abeyance pending the action of your incoming President, Dr. O. O. Feaster. It should be understood that this committee will not only advise in the successful carrying out of the medical aspects of desired public health programs, but also have a voice in the actual formation of these programs. Previously, advisory committees have been consulted only in the carrying out of health programs and not in their actual formation before the allotment of funds has been apportioned, and basic policies established. It would seem to me that the Chairman of the Economics Committee should be a member of all committees dealing with policies, economics, etc., so that uniform policies will prevail in all our committee activities. Prior to taking action, County Medical Societies should be urged to submit all medical practice contracts to your State Economics Committee for careful consideration of certain basic principles which we as individuals should demand. Your State Economics Committee is the proper one to confer with governmental and private health agencies in dealing with health matters.

From my observations and travels throughout the State during the past year, I believe that the time has arrived for the employment of a full time business manager by the State Association. Your present part-time business manager, Dr. Stewart G. Thompson, is one of the most efficient men that I have ever had the pleasure of working with. The business side of medicine has increased to the point where if efficiency is to be maintained it will require the full time of an individual. The benefits to be derived are so diverse that time will not permit enumeration. The following recommendations are urged:

1. The appointment of a committee consisting of your President, President-elect, Secre-

tary-Treasurer, Chairmen of the Executive and Economics Committees, and a past President to consider the advisability of employing a full-time business manager and report the recommendations at the next annual meeting of this Association.

2. That the Constitution and By-Laws of this Association be amended so that all standing Committees consist of six members appointed one from each of the six districts of the State in accordance with the present set up of the Executive and Scientific Work Committees.
3. That the number of councilors be reduced from twenty-one to six similarly, one from each of the six districts.
4. That the Chairman of each of the standing Committees be an advisory member of the Executive Committee.
5. That your State Association sponsor the formation of six district medical societies corresponding to the six districts of the State Association and that each of these district societies be represented on the membership of the various committees of the State Association. Thus each District Society will be thoroughly conversant with state activities.

Such a reorganization will cement the interest of individual physicians in organized medicine.

The social workers are becoming highly organized and it is apparent that the future medical practice will in the last analysis depend not only upon individual effort, but more upon the organized effort of every county medical society to which each individual member must strive to contribute his support, as a member of our Association and a true disciple of Aesculapius, working in the interest of scientific medicine and of the public whom he serves.

It has been possible for me to accept every invitation to meet with committees and to address various groups during the year with the exception of one, which my absence from the state prevented. On these occasions opportunity was sought to mold public opinion and explain the medical viewpoint on social and state medical problems. Physicians are urged to grasp every opportunity to address groups and inform the public of their attitude on health matters, and point out the defects of social medicine. Inevitably such policies must yield results.

The trained nurse is the doctor's lieutenant; therefore they are entitled to our wholehearted professional cooperation and support in their present economical situation. In the early part of December, the FERA nursing service was discontinued to be reopened last February under the WPA. There was a state-wide project plan submitted to Washington, but for some unknown reason, the Federal officials broke down the nursing project into sixty-seven individual projects resulting in the payment of the security wage scale in the county where the nurses concerned were employed. Thus salaries ranged from $39.00 to $75.00 a month. The girl who clerks in the store with no previous training is paid more than $39.00 a month. I feel that we should cooperate with the Nurses Association in every manner possible.

Permit me to take this opportunity to thank every member for his cooperation during the past year and especially the various committee members for their efforts, advice and support.

To accomplish political objectives it is essential to weld together all the allied professions of the ethical healing arts in order to bring about those social, legal and economic reforms in medicine which we failed to achieve individually.

Escambia County was the first to form a County Political Health Council composed of members of the local medical and dental societies, the retail druggists and registered nurses. The purpose of this Council is to provide a medium for discussion and concerted action on matters of common interest to the above professions. No one is eligible for membership unless he be a member in good standing of his respective association and is a registered voter.

The influences of such an organization will be of inestimable value to the allied professions through voting power. Up to this time many such Councils have already been organized in the state and it is hoped that every county in the state will be so represented within the next few weeks. These Councils are not affiliated with the State Medical Association, which however sponsors local professional and political-mindedness. The Legislative Committee of your Association will report a number of medical bills that will shortly be sent to each County Society requesting that they acquaint their State Senator and Representatives with their contents and pledge each one to support these bills when they come up next year for passage. In conclusion let me say that I feel that an aroused medical profession will certainly rally to direct its own destiny.

PROCEEDINGS

of the

SIXTY-THIRD ANNUAL MEETING

of the

FLORIDA MEDICAL ASSOCIATION, Inc.

HELD ON THE S.S. "FLORIDA"

APRIL 27, 28 and 29, 1936

FIRST SCIENTIFIC ASSEMBLY

The Scientific Assembly convened at 2:00 p. m., Monday, April 27th, in the dining room on board the S. S. "Florida."

The following papers were read and discussed:

1. "Present Day Conception of the Management of Prostatic Obstruction," Louis Orr, Orlando. (Read by Dr. Doran T. Rue in the absence of Doctor Orr).

2. "The Cautery in Acute Epididymitis and Orchitis," J. C. Vinson, Tampa.

3. "Collapse Therapy of Pulmonary Tuberculosis," Louie Limbaugh, Jacksonville.

"The Surgical Treatment of Pulmonary Tuberculosis," Kenneth A. Morris, Jacksonville.

"Moving Picture Demonstration of X-ray Films," W. McL. Shaw, Jacksonville.

Moving Picture: "The Surgical Treatment of Pulmonary Tuberculosis."

4. "Sulphur, the Forgotten Remedy," Hubbard Gates, Bradenton.

FIRST GENERAL SESSION

The First General Session of the Florida Medical Association was called to order at 4:00 p. m. Monday, April 27th, in the dining room on board the S. S. "Florida," by President Herbert L. Bryans.

President Bryans introduced Dr. Arthur G. Fort, delegate from Georgia.

No Alabama delegates were present.

Dr. Henry E. Perry, a visitor from Michigan, was introduced and made a brief address.

Reports of Committees:

The Committee on Legislation and Public Policy was not represented.

The report of the Committee on Medical Education and Hospitals was read by Dr. J. C. Davis, as follows:

REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

The members of your Hospital Committee failed to get together this year. One member was claimed by death and his successor has not been appointed. The chairman of your committee had an interview with the president of the Florida Hospital Association and has also had some correspondence with the American Medical Association relative to the standardization of hospitals. The American Medical Association is not very definite other than standardizing those accredited for internship, while the American College of Surgeons is more specific in adopting a set of requirements.

There have been no changes in the number of hospitals carried on the Approved List for Interns of the American Medical Association in Florida. There are many hospitals in this state listed in the directory of the American Medical Association that should be designated as "A," "B," and "C." Group "A" may be listed under two heads: (1) hospitals approved for internship; (2) hospitals that do not contain a sufficient number of beds to be approved for internship but meet all other requirements. Group "B" hospitals with twenty-five beds or less, otherwise meeting the minimum requirements of standardization by the American College of Surgeons. Group "C" hospitals registered by the American Medical Association that do not come up to standard in equipment or efficiency of personnel. Many hospitals of the latter type have a graduate or practical nurse only and permit members of the family or inexperienced nurses to "special" or sit with patients. These institutions are often private and the personnel inefficient. Group "C" should be dropped from the list of registered hospitals. The standardization of hospitals should not be

based upon the number of beds and nurses, but more on the type of service rendered and the rating of the physicians doing the work. Many hospitals of less than twenty-five beds have a much lower mortality rate from major surgery than larger hospitals where every licensed practitioner is permitted to operate. However, it is just as difficult in small hospitals to prevent the novice from doing surgery as in the larger ones. I find in checking available records that the mortality rate from surgery is in direct ratio to the amount of surgery being done by various operators; for example, the better trained man naturally does more work and a man doing from two to three hundred operations per year has a mortality rate of two to three per cent in general surgery whereas the man doing from thirty to forty operations per year has a mortality rate of twenty-five per cent or more and the occasional operator doing less than ten per year frequently has a fifty per cent rate. While we are talking of raising medical standards by legislation we probably should be trying to legislate some requirements before a physician is permitted to do a major operation. In the highly specialized specialties this is not necessary, but every man by virtue of the fact that he is an M.D. should not be permitted to endanger the lives of those intrusted to his care by attempting to do that of which he is not capable. The crying need today is for diagnosticians, internists and pediatricians. There is certainly a great opening in the smaller cities as most men locating these days designate themselves as specialists in surgery while attempting to do everything. A young graduate recently told me that he was going to be a specialist in medicine and surgery in all diseases to which men, women and children of all nationalities might fall heir.

A short time ago I had a personal interview with Mr. Holcombe, superintendent of St. Lukes Hospital of Jacksonville, relative to Hospital Insurance or Group Insurance. From their experience and that of hospitals in other states I am convinced that the undertaking is not without merit. The hospital is aided financially and the insured is able to secure hospital services otherwise unavailable and better enabled to pay his physician. I commend this to you for your consideration, the allocation of part of saving bank money to hospitals for caring for indigent patients.

Respectfully,
J. C. Davis, Chairman;
Eugene B. Maxwell.

On motion made, seconded and carried the report of the Committee on Medical Education and Hospitals was unanimously adopted.

The report of the Committee on Necrology was read by Dr. Homer Pearson, in the absence of Dr. Christ, as follows:

REPORT OF COMMITTEE ON NECROLOGY

During the past year, our Association lost, by death, the members whose names are listed below:

Bundy Allen, Tampa
Henry C. Babcock, Miami
Haynes Brinson, Kissimmee
James H. Colson, Gainesville
Edgar S. Estes, St. Augustine
Mary Freeman, Perrine
C. H. Glidden, Ft. Pierce
George E. W. Hardy, Tampa
Herrman H. Harris, Jacksonville
John W. Hodges, Miami
Harry Dash Johnson, Daytona Beach
E. H. McRae, Tampa
W. C. Person, Orlando
William C. Pumpelly, Ft. Pierce
F. G. Renshaw, Pensacola
David M. Seymour, Bushnell
J. A. B. Sinclair, Miami
Samuel H. Toy, Umatilla
Edmund W. Warren, Palatka
J. Blake White, Daytona Beach

Where possible, obituaries have appeared in the Journal relative to the deaths of these doctors. Tributes have been paid to them in the different communities where they practiced.

May we, at this time, stand in a moment of silence, in reverence and respect to the memory of our departed colleagues.

C. D. Christ, Chairman;
W. C. Roberts,
Frederick J. Waas,
Isaac M. Hay,
John R. Boling,
Walter C. Jones,
Joseph Halton,
Harry C. Galey.

Motion made, seconded and unanimously carried, to adopt the report of the Committee on Necrology and for the members present to stand for one minute of silent prayer in respect to the their deceased colleagues.

Silent prayer for one minute.

The report of the Public Relations Committee was read by Dr. J. Ralston Wells, as follows:

REPORT OF COMMITTEE ON PUBLIC RELATIONS

The Public Relations Committee of 1935-1936 has been active along practically one line of endeavor, and that is the radio broadcasting. The files of manuscripts for the basis of talks have been utilized twice only. Both times we hope the request has been fulfilled satisfactorily to the doctors so requesting.

The radio broadcasts have been put on through the courtesy of our state university station, WRUF every Sunday evening at six o'clock, starting September 15th, 1935. There have been three failures to appear by the essayists. The efficiency of broadcasts is impossible to estimate.

At a meeting of the committee it was decided to attempt a formal symposium upon the very prevalent subject of Medical Economics. Your committee obtained literature on this subject from the American Medical Association, and the contrary side from the Rosenwald Foundation. The literature received from the American Medical Association has been the part utilized for presentation. The symposium consists of eleven broadcasts on successive Sunday evenings, starting March 1st, 1936, and with one exception, has been filled to date.

This year, following the idea presented at our last convention in Ocala, the essayist's name and place of residence has been announced over the radio at each broadcast. The central office, through the courtesy of Drs. Shaler Richardson and Stewart Thompson, has provided 12 weekly typewritten copies of announcements to newspapers throughout Florida, in time to have the speakers and their subjects published in the newspapers on the Sundays of the broadcasts. This was started six weeks ago, and whether or not it has borne enough fruit to warrant the work entailed, I do not know. However, clippings from newspapers indicate that these notices are published. But, the continuation of this, we respectfully leave to the wishes of this convention. The speakers who have written essays, and for the most part have delivered them in person, to date, are as follows: Henry Hanson, Julius Davis, Theodore F. Hahn, M. M. Hannum, W. C. Chowning, Fred Puleston, Hugh West, Maximilian Stern, Thomas Palmer (2), L. L. Whiddon, W. C. McConnell, Fred Mathers, George M. Green, Edwin H. Andrews, L. W. Glatzau, J. S. Turberville, George C. Tillman, Homer Pearson, O. O. Feaster, T. H. Bates, W. H. Spiers, and Edward Jelks.

We owe a considerable debt of appreciation to the station at Gainesville, and personally to its very able director, Major Garland Powell, remembering that this service is given to us, not only with the greatest of cooperation and courtesy, but is without charge to the Association.

The meetings of the committee have been infrequent owing to the relatively long distances necessary to travel for the majority of the committee members. The matter of carrying this same line of work on for another year rests entirely with the Association. If the work that we are attempting to accomplish is being accomplished, the matter of writing a paper, the energy, the time, and the distance to travel, is worth while. On the other hand, if we are not accomplishing our purpose, it is time, energy, and the radio broadcasting facilities wasted. Aside from the difficulties of each man in delivering a paper, which is usually not over once a year, it is of some work to your committee to obtain consent of various men throughout the state to present a paper. This year we have had one symposium on Medical Economics, but there has been no attempt to suggest subjects for the various essayists, allowing each man to suggest and write upon the subject that he feels best equipped to handle.

The continuation of the work of this committee as such, depends on first, personnel, and second, the willingness of the men throughout the state to cooperate. The hardest part, let me reiterate, is to obtain the consent of our various members to present papers. If the policy and the procedure of this committee of this year has met with the approval of the convention, I would like to request on behalf of the committee and its chairman for the next year, that volunteers be asked for at this time, and after the commit-

tee has been decided upon, that these volunteers be contacted for dates that will be acceptable to them.

The itemized statement of expense attached for $34.16 is recommended for reimbursement.

Respectfully submitted,

J. Ralston Wells, M.D., Chairman:
Henry C. Dozier, M.D.,
William H. Spiers, M.D.,
Hubert A. Barge, M.D.,
Thomas E. Buckman, M.D.,
H. Mason Smith, M.D.

It was moved, seconded and carried that the report of the Committee on Public Relations be adopted.

The report of the Committee on Post-Graduate Course was read as follows:

REPORT OF COMMITTEE ON MEDICAL POST-GRADUATE COURSE

The Medical Post-Graduate Course Committee wishes to report that it is now properly incorporated and functioning as a corporation.

After numerous meetings and much correspondence, the schedule is now complete for the 1936 short course to be held in Gainesville, June 22nd to 27th, inclusive. The programs are being distributed at this meeting. Announcements have already been made through the Florida Medical Journal. Further information will be available in the May issue. Six lectures in Neuropsychiatry will replace the lectures in Orthopedic Surgery and Venereal Diseases. Two symposia have been arranged for two evenings and round table discussions for two evenings will replace the daily luncheon meetings.

The attention of the Association is called to the fact that for two previous years the University of Florida has requested $100.00 to cover incidental expenses to the General Extension Division. No demands were made the first year. The Committee has managed to evade payment for two years but this year the Extension Division would not agree to do the printing until the chairman of the Committee personally guaranteed it would be paid. The Committee has been informed by the Extension Division that this $100.00 will not cover their actual expenditures. Your attention is called to the financial report showing that, up to the 1936 session, we have managed, through registration fees collected and without paying the University of Florida anything, to break even. We have been very fortunate on several occasions in having the cost of bringing a speaker down taken care of by some other source. For instance, all the expenses incidental to bringing the lecturer on venereal diseases here were defrayed by the United States Public Health Service. This year not only do we have no assistance in this way but the lecturer for neuropsychiatry must come from a great distance. Unless the attendance is larger than in any previous year we are going to find ourselves called upon to use a considerable amount of the funds appropriated by the Association. The attendance at the session last June was better than any preceding year, but it is the opinion of the Committee and those particularly interested in the short courses that the value to be derived from the course is such that a much greater number of physicians should be attracted.

FINANCIAL STATEMENT OF COMMITTEE ON MEDICAL POST-GRADUATE COURSE
1935

Balance in Bank, May 15, 1935	$ 35.78	
Receipts:		
Registration: 125 @ $5.00	625.00	
Florida Medical Association	500.00	
Luncheon Tickets Sold	114.00	
		$1,274.78
Bills Paid:		
Pepper Printing Company (printing)	$ 9.75	
Doctor F. L. Adair (expense account)	120.45	
Doctor C. R. Edwards (expense account)	69.94	
Doctor O. W. Bethea (expense account)	45.00	
Doctor Horton Casparis (expense account)	95.00	
Doctor E. Novak (expense account)	84.94	
White House Hotel (Dr. Bethea's hotel exp.)	26.05	
Hotel Thomas (Dr. Adair's hotel exp.)	9.00	
Hotel Thomas (Dr. Edwards' hotel exp.)	14.20	
Hotel Thomas (Dr. Novak's hotel exp.)	12.00	
Hotel Thomas (Dr. Campbell's hotel exp.)	6.10	
University Cafeteria (Meal Tickets $114.00) (Faculty Meals $9.00)	123.00	
Russell Mitchell (student assistant)	6.00	
Burns Dobbins (student assistant)	10.00	
Doctor T. Z. Cason (stamps)	5.00	
Telephone, Telegraph, Stamps, and Bank Tax	5.59	
S. L. Scruggs (chairman American Legion)	5.00	
Doctor C. Jackson (1934 account)	90.00	
Hampton, Jordan, and Lazonby (Charter fee)	37.50	774.52
Balance in Bank, Feb. 22, 1936		$ 500.26
Outstanding Bills	None	

Florida Medical Association Graduate Course, Inc.

George C. Tillman, *Treasurer.*

Respectfully submitted,
T. Z. Cason, M.D., Chairman;
George L. Cook, M.D.,
Hugh West, M.D.,
George C. Tillman, M.D.

It was moved, seconded and carried that the report of the Committee on Medical Post-Graduate Course be adopted.

The report of the Committee on Cancer Control was made by Dr. F. Clifton Moor, as follows:

REPORT OF COMMITTEE ON CANCER CONTROL

This year, as in previous years, it has been thought best that although we have a committee organized and have had a session some time back, the actual work be carried on by the members of the committee with each member being more or less autonomous in his district. Through the help of the national organization every one of the committee members has a projectoscope and some cancer films. These are kept available to be used whenever a cancer program can be put on. The opportunity to put on these programs comes more or less unexpectedly.

We have laid down certain general principles for the governing of the organization and then simply put it up to the various members of the committee to do whatever they could toward spreading cancer knowledge.

The committees have been in most instances relatively active. The report from Dr. Holden who has the Jacksonville district mentions one half dozen organizations before whom programs have been presented. Dr. Raap in the East Coast district has hooked up with the Pilots Club and carried on a relatively active campaign through that organization.

Some weeks ago I wrote to thirty-five hospitals in the State to get some idea of the amount of work on cancer done in the hospitals. I received replies from fifteen hospitals with a total of eleven hundred beds. It might be of some interest to the profession to know just what information was gained from that questionnaire. Eleven hundred beds includes practically all of the larger hospitals and a good many of the smaller ones. They reported that during the previous year 161 patients have had surgical treatment for cancer; 271 have had radiological treatments; 97 have had combined treatment and 254 have been diagnosed but not treated because the condition was so far advanced that treatment would have been more or less hopeless. There has been no opportunity to analyze these figures but it demonstrates that it is still a problem.

F. Clifton Moor, Chairman;
William P. Adamson,
James M. Hoffman,
Gerry R. Holden,
Gerard Raap.

On motion made, seconded and carried the above report was adopted.

The report of the Committee on Medical Economics was read by Dr. J. S. Turberville, as follows:

REPORT OF THE COMMITTEE ON MEDICAL ECONOMICS

Your committee has gone over much of the current literature on Medical Economics, and has found a good deal of interesting matter, but very barren of fruitful suggestions. There has been a good deal of fine research and statistical work done, which show us very clearly what not to do, but what to do is conspicuous by its absence. We have about reached the conclusion that there is very little we can do about it.

Medical Economics in plain English is the remunerative side of the doctor's life, and all factors related thereto. The professional economist proceeds very well with the discussion of the doctor's affairs while dealing with the monetary cost of education, equipment and operating expenses, but from this point onward he encounters such variables and imponderables, as intelligence, general education, training, skill, personality, and lastly the response of the patient to treatment. This leads nowhere in the direction of any standardized price for medical services, as no one but the physician himself can say what is the proper fee for any particular service. Customs have made some fees in every community a sort of uniform charge, but general economic variations, special circumstances, etc., often cause changes in these. The professional economist, therefore, has not given us much help. Your committee reports of 1934 and 1935 are so thorough and so fresh in the memory of all of us that we think it superfluous to restate the general conclusions reached, but

in the course of this report will mention some of the points for the purpose of emphasis.

In this report we will discuss the care of the indigent poor and the care of the low income group; the well-to-do are not a problem and need no discussion. We will state in the beginning that at the risk of being accused of dogmatism and in the interest of brevity our conclusions will be stated without much argument, and give trends without supporting statistics.

Indigent Poor: Last autumn and winter, we met with our President, and members of the executive committee, the State Health Officer, a representative of the State Welfare Board, druggists, dentists and other interested friends, and formulated a plan to furnish medical care, and dental care to the indigent. This was a failure on account of lack of funds. This is reported in the Florida Medical Journal, date of October. There is no need to repeat this. Whether there will ever again be any attempt to relieve this situation by Federal funds is questionable. The State has a Welfare Board without funds, and as things look now there is not much likelihood of securing any appropriation large enough to be of any real benefit, certainly not to the doctors. We, therefore, are virtually where we were with the exception of the presence of an organized Welfare Department. Each community now, as always, must take care of these people. The doctors will respond nobly, but more cautiously, and are going to be more jealous of their rights. They are going to demand a voice in all boards of social or other community welfare. They will not be the willing servants of extra professional managers. They will work in cooperation, but not by direction.

The Social Welfare Board has an opportunity to do a great work in the care of these unfortunate people in cooperation with the doctors. We need them, they must have us! The law of today gave them a bad start in not giving representation on the State or District Boards to the medical and dental professions, and the Governor also forgot them. Nevertheless, we think we can safely say that the doctors and dentists will meet the Welfare Department half way in any cooperative movement, but that strenuous opposition will be made to any movement looking to the establishment of clinics by part or whole time employees, or without the consent and in cooperation with organized medicine and organized dentistry, as represented by their county societies.

This committee thinks that there should be established in each County a board of control, made up of physicians, dentists, welfare workers, members of Board of Revenue, and that all plans should maintain doctor-patient relationship. We feel sure that where there is no money for medical or dental services that this will be donated. It will be up to the Welfare Department to see that politicians and grafters do not abuse this service. Clinics as have been operated heretofore have been objectionable to the professions on account of lay control. If the County Societies desire and are willing to operate clinics we can see no objection, but they must be free from lay control. It would be a great misfortune for organized medicine to lose contact with the poor. We would lose a spiritual value that could not be compensated for in any other way.

The Low Income Group: When we discuss economics of this group there is encountered all kinds of suggested panaceas; lodge practice, contract practice, group insurance, workmen's compensation, State and Federal, sick and unemployment insurance, prepayment plans of hospital insurance, State Medicine, etc. We can group and discuss these plans together, for no matter what euphonious name any one of them masquerades under they are all just plain sickness and health insurance.

There are certain basic facts that must be considered in any talks on sickness and unemployment insurance. It has been said that the most unchanging thing in this world is human nature. It is human nature to try to get what you have paid for whether you need it or not; it is human nature to hold fast to what you have; it is human nature to favor the party that has you employed; and it is human nature to think the latter whether it is true or not. Now, when a sickness or unemployment insurance contract is entered into, there is immediately created two hostile groups, the insured who wishes to get back what he has paid for and often is fraudulent in his demands, and the insuror who resists these demands, often where they are legitimate. The doctor is called on to treat the sickness and to determine if it is compensable. He is called to act in a semi-judicial capacity for which he is not trained and for which he has no taste. If he is paid by the insuror he will be inclined to favor

his view point in doubtful cases, and if he is paid by the insured it will be the reverse. He stands to lose the friendship of either party in every case of sickness. Can you imagine a worse predicament? Yet, that is the situation in every case of sickness and you must readily see the great distraction from the purpose of his calling. This situation alone is sufficient to make any honest doctor opposed to this kind of insurance. There are many other objections, namely, lay control and direction. Most plans disturb doctor-patient relationship, promote underbidding for contract work and insurance work, and result in deterioration in practice on account of over work or the presence of compensation neuroses, etc.

It is the opinion of this committee that organized medicine should oppose with all of its power every effort to force any of these schemes for payment of medical services. No kind of sickness insurance will be satisfactory until the psychology of the human race changes. Some plan in every community should be worked out whereby these people can pay their bills by deferred payments. This would be the best solution for all concerned. I think the hospitals could be talked into such a scheme. The pooling of all charges, medical, dental, drug and hospital, with some central agency for handling as one item would be very helpful, and facilitate its collection. If the patient was employed and his employer was approached with half a dozen items for collection he would not consider it, but, if he had one item he would be interested in most instances, because it would facilitate handling through the office, and if he had many employees who had to have their affairs handled through this central agency it would still further simplify the transaction. There is such a plan in Wayne County Michigan and it will be well worth the time and trouble if all the County Medical Societies would investigate this plan. The plan in Washington, D. C. is somewhat similar. However, it must be understood that this setup must at all times be under the control of the County Medical Societies or it will degenerate into a collecting agency.

Insurance or contract practice is not bad within itself; it is the attitude of all those concerned that makes it bad. It creates a situation, however, that is impossible of fair adjustment as long as the human mind is as we find it. Unemployment and sickness insurance in the hands of the State or Federal Governments would degenerate into intolerable bureaucracies in a short time because of the possibilities of its manipulation into vote buying, etc. The Welfare Board can be of great assistance to this low income group by helping them plan their payments, and can remove many from the indigent group to this group.

We have tried to find out, through the secretaries of the County Societies, how prevalent are lodge practices, contract practices, group insurance for sickness, etc., and have the following to report:

Lodge Contracts: None, except one negro contract.

Group Insurance: None.

Industrial Contracts: Four.

Attitude toward such practice: Four had not discussed it with their societies, one was in favor of it, and twelve were opposed to it. There are no indigent doctors or members of their families in Florida so far as we can determine. There are no marked discriminations in the premiums for liability insurance for doctors, and fees for life insurance examinations are uniform.

Your Committee has been unable to contact the Industrial Insurance Commissioner. A copy of the attached letter will give some idea of what has been attempted.

"Tallahassee, Fla.
"April 25th, 1936.

"Mr. Wendell C. Heaton,
Chairman Florida Industrial Commission,
Tallahassee, Fla.
"Dear Mr. Heaton:—

"In accordance with your letter of a few days ago, I telegraphed for an interview today. Your secretary informs me that you are absent.

"This is the second trip I have made to Tallahassee to see you, but have failed both times. I have also written you on several occasions and have had two replies but neither gave information on the subject mentioned in my letters.

"I am presuming that your failure to meet me today is unavoidable, therefore I am making this final appeal which I am delivering in person at your office.

"To somewhat summarize the contents of my previous letters I am asking the following questions:

"No. 1—How do you contact the general profession?

"No. 2—What procedure have you for settling disputes over bills for services?

"No. 3—How do you arrive at your decisions over purely Medical and Surgical matters?

"No. 4—What would be your thought about having an associate commission made up of: a representative of organized medicine; a representative of organized insurance carriers; a representative of organized industry; and a representative for organized labor, that you may call on for consultation when knotty problems arise?

"No. 5—Have you formulated regulations for carrying the law into effect and if so may I have a copy for publication in the Florida Medical Journal?

"No. 6—What do you think of having each County Medical Society name a number of its members from which you might select local medical referees?

"No. 7—In case you think the question in No. 4 is impracticable what would you think of the idea of having the President or the Executive Committee of the Florida Medical Association name several members of the Association from which you might select a referee for your office?

"No. 8—Will student nurses be considered employees under the Florida Compensation Law and require coverage?

"I contacted President Bryans and he informs me that Dr. Kenneth Morris has no official standing in the Florida Medical Association. I am sure in a prior communication in which you spoke of discussing matters pertaining to the doctors that you were not speaking with any one authorized to speak for the Association on this subject.

"I am not requesting this information as an individual but as an authorized representative of the Florida Medical Association, whose membership is about 1,000 doctors.

"If you care to reply you may send Nite Letter to me on S. S. Florida, Miami, Fla., care the Purser. The ship will sail about 9:00 A. M. Monday, April 27th, 1936. Send bill to me for Nite Letter or to be held by Purser for collection.

"Hoping to hear from you, I am

"Yours very sincerely,

(Signed) J. S. TURBERVILLE,
Chairman Florida Medical Assn's
Economics Committee."

Your Committee is unable to understand why we have not received an audience or reply to our inquiries. I am sure that no questions have been asked that are of an improper nature. Therefore, I would suggest that the succeeding committees do not abandon the ideas of authorized representation of the Florida Medical Association in the capacities mentioned in the above letter to the industrial insurance commissioner.

It has again been talked that certain of the ophthalmologists are getting rebates from certain optical companies on spectacle prescriptions as a differential between wholesale and retail prices. This was mentioned by the Economics Committee in their 1934 report. It is condemned by both the American Medical Association and the American College of Surgeons. It is on a par with fee splitting; it is mercenary; it violates a sacred trust; and is condemned by all right-thinking men. It is inimical to the whole medical profession because it cheapens us in the eyes of all good people. I can not think that many of the fine men we know are guilty of such practices and feel that it must be through the thoughtlessness of a few. Nevertheless, the time has come for them to put their house in order if such practices exist. Your committee feels that it is only sufficient to mention this pernicious practice, but if it continues it will be the duty of the succeeding committees to take the necessary steps to stop it, in order to protect the good name of organized medicine.

In this connection we wish to call attention to a species of petty graft that is more or less in its inception, not by doctors, but doctors are the unwilling victims of it. I refer to the practice of certain State officials getting free physical examinations for themselves, their relatives and friends at the Chattahoochee Hospital. We need not tell you, for you already know, that this is the meanest kind of graft, for it is not only getting something for nothing, but it is in a measure coercive of services in that on account of the influence of the people concerned the doctors are forced to do, or run the risk of discharge from service. The remedy is for each of you to contact all candidates from Governor down, and tell them what you think of it. If you do not, the practice will grow to such proportions that it will blow up of its own momentum and cause a great scandal that may touch the good name of some of the members of our own profession.

J. S. TURBERVILLE, Chairman;
LOUIE M. LIMBAUGH,
WILLIAM C. THOMAS,
W. W. KIRK,
HENRY C. DOZIER.

On motion made, seconded and carried, the report of the Committee on Medical Economics was unanimously adopted.

The report of the Advisory Committee to the Woman's Auxiliary was read by Dr. Gordon H. Ira, as follows:

REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The Advisory Board met with the President of the Woman's Auxiliary to the Medical Association, Mrs. Veal, together with her board, in September. This meeting was held in Orlando. Plans for the year were made and a charge was sent to each auxiliary as follows:

"Dear Mrs. .....:

"After careful consideration of all work at hand by the Advisory Board and State Officers of the Woman's Auxiliary to the Florida Medical Association, recognizing that a few things well done are more commendable than many poorly carried out, I am giving you as President of the County Woman's Auxiliary the following charge for the year's work:

"1. Give as wide publicity as possible to the American Medical Association broadcast of medical emergencies on Tuesday at 5:00 p. m. over the National Broadcasting Company, and as has already been requested by your State Program Chairman, secure the program for your station in preference to a local broadcast if possible.

"2. Make plans for the use of the study envelope concerning 'Healthy Hearts' at one meeting this winter.

"3. Read to as many organizations as possible the three-minute talk, 'The Necessity of Health Cards for Household Servants.'

"4. Prepare an exhibit for the State Medical Association Meeting in May.

"5. Make every effort to fulfill your Hygeia quota.

"6. Added suggestion: The National University Extension Association has chosen 'Medical Service at Public Expense', for debate for 1935 and 1936. We hope that the Auxiliary members will endeavor to assist debators from their own high schools to secure authentic literature on this subject and an understanding of the attitude of the medical profession.

"We are particularly anxious that all auxiliaries carry out a uniform program in part. There are many other forms of activities for those of you interested in other fields of which your program chairman will be glad to advise."

Reports indicate that the A. M. A. broadcasts have been well received.

I wish to comment on the work of one society. The Marion County Auxiliary sent a letter to each P. T. A. in the county asking if there were any medical subject that they would like to have presented to them by a member of the Marion County Medical Society. And, as a result, several meetings, enthusiastically attended, have been held, with such subjects as hookworm, malaria, pellagra, and cancer being discussed.

Another item that the Auxiliary is emphasizing is the distribution of authentic A. M. A. pamphlets dealing with "The Story of Life" for children, and boys and girls in their teens.

And one of the most important functions of the Auxiliary this year has been to assist the high schools where the following subject was chosen for debate:

"Resolved: That the several states should promote a system of complete medical care to be available to all the people at public expense."

The Julius Rosenwald Fund has emphasized the subject and has sent to every high school material for the debate, but the material for the affirmative excells that for the negative. Dr. Olin West and Dr. Walter Bower requested, through the National Woman's Auxiliary, the assistance of every county auxiliary in furnishing negative information to all who are debating this subject of furnishing medical service, at public expense, to all.

If any medical society is interested or has been asked for this literature, I will be glad to give you more information about it.

Another reason why the auxiliary has as its chief objective, "The Disseminating of Health Education Information" is found in the following resolution of the House of Delegates of the American Medical Association at its Philadelphia meeting, in 1931:

"Whereas, the periodical Hygeia, the Health Magazine, published by the American Medical Association, is the only authentic health periodical available in this country; and

"Whereas, this periodical was established by the Board of Trustees on recommendation of the House of Delegates to be the official voice of American Medical Association in educating the public in matters of health; and

"Whereas, it is the best medium for reaching the teachers of the young, and the pupils in schools throughout the country, informing them of the progress of medical science and of scientific means for the prevention of diseases; therefore be it

"Resolved: That the House of Delegates urge the Woman's Auxiliary of the American Medical Association, including the county, state and national organizations, to recognize as one of its chief activities the promotion of the distribution of this publication through parent-teachers' associations, boards of education and similar bodies, interested in education."

In closing, may we make this observation. The Woman's Auxiliary to the American Medical Association is part of the national set-up. They have a work to do, and a place in organized medicine. The quality of the work carried on by the Florida auxiliary has been above the average. In a letter to the Florida Auxiliary from Mrs. V. E. Holcombe, the national pro-

gram chairman, with reference to the Florida work, she said:

"The aims set forth in your joint letter of Advisory Board and State Officers of Woman's Auxiliary is one of the very best I've received. Let me commend you for this very splendid Program Work."

Their desire is to be nothing but an auxiliary, with a desire to help. Your advisory committee wishes to recommend that you give them your loyal support. Advise them, work with them, and when your county society is asked for a speaker to appear before a woman's club, furnish them with a speaker that will enthusiastically help them with their main program, Health Education.

Respectfully submitted,
GORDON H. IRA, Chairman;
L. M. ROZIER,
EUGENE G. PEEK,
W. C. MCCONNELL.

On motion made, seconded and carried, the report of the Advisory Committee to the Woman's Auxiliary was adopted.

The report of the Inter-Relationship Committee was read by Dr. J. Knox Simpson, as follows:

REPORT OF THE INTER-RELATIONSHIP COMMITTEE

Your Committee is glad to be able to report a very active year, there having been organized in the state more than a dozen Allied Health Councils. All of the individual councils having agreed to invite the graduate nurse organizations to join with them, now establish a very influential organization consisting of the combined forces of the physicians, dentists, pharmacists and nurses. In addition to creating a more friendly and harmonious feeling between these four organizations, a program consisting of health, civic, and political affairs has been mapped out which promises to be far-reaching in its scope and benefits.

The Committee while elated over the enthusiasm that is being demonstrated feel that it will not be amiss to caution the individual councils against too much publicity relative to the political aspect of our organization, believing the profession will come nearer to perpetuating the time-honored respect of the laity by stressing additional objects. In order to establish a basis upon which all individual councils should organize, your Committee recommends for your approval the following:

CONSTITUTION AND BY-LAWS

ARTICLE I—NAME

The name of this organization shall be the Florida Allied Health Council. The individual councils shall be known as "....." County Allied Health Council.

ARTICLE II—OBJECTS

Section 1. To encourage its members to become more interested in legislation and matters affecting the public health.

Section 2. To elevate ethical professional standards.

Section 3. To safeguard the general public from impositions and misrepresentations of unscrupulous practitioners of the healing arts.

Section 4. To promote better understanding between its members and society particularly in the interest of public health.

Section 5. To encourage in all its members more active participation in all worthy civic affairs.

ARTICLE III—MEMBERSHIP

Section 1. There shall be two classes of members.

Section 2. Active members shall consist of physicians, dentists, pharmacists, and nurses. All shall be in good standing with their respective local and state professional organizations.

Section. 3. Honorary members. Any person who through eminent service has promoted the interests of public health in a manner approved by the officers and membership at large may be elected to honorary membership.

ARTICLE IV—OFFICERS

Section 1. Officers shall consist of a President, a first Vice-President, a second Vice-President and a Secretary-Treasurer, all of whom shall be responsible to the Board of Directors for their actions.

Section 2. The Board of Directors shall consist of two members from each of the local organizations of physicians, dentists, pharmacists, and nurses.

ARTICLE V—MEETINGS

Section 1. Regular meetings shall be held once each month.

Section 2. Special meetings shall be called by the President at the request of the majority of the Board of Directors, or at the request of at least three members from each of the organizations represented in the Council.

Section 3. The annual meeting shall be called during the month of April of each year.

ARTICLE VI—QUORUM

Sixteen members shall constitute a quorum.

ARTICLE VII—AMENDMENTS

Amendments of this constitution may be made at any regular meeting by the affirmative vote of two-thirds of the members present, provided that notice of proposed amendments shall have been presented at the meeting prior to that at which they are to be voted on.

BY-LAWS

ARTICLE I

Election of Officers

a. Officers shall be elected by the Council for a term of one year or until successors are elected.

b. Nominations for officers shall be made from the floor and elected by voice vote except in the event that more than one nominee is considered for any one office, when the vote shall be cast by secret ballot.

c. Each organization that is a part of the council shall elect and present the names of two of its members to represent them on the Board of Directors.

ARTICLE II

Members

a. The procedure governing the admission of members shall be determined by the Officers and Board of Directors.

ARTICLE III

Dues

When and if it becomes necessary to assess dues the amount shall be determined by the membership.

ARTICLE IV

Duties of Officers

a. The President shall preside at all meetings. The first and second Vice-Presidents, respectively, shall preside in the absence of the President.

b. The Secretary-Treasurer shall keep a correct record of all meetings of the Council, and shall collect and keep correct account of all dues or moneys belonging to the Council.

c. The Board of Directors shall together with the officers be the governing body of the Council, and shall censor all publicity connected with the operation of the Council.

Respectfully submitted,
WILLIAM M. ROWLETT, Chairman;
J. KNOX SIMPSON,
CHARLES D. CLEGHORN.

On motion made, seconded and carried, the report of the Inter-Relationship Committee was adopted.

REPORT OF COMMITTEE ON TUBERCULOSIS AND PUBLIC HEALTH

During the last year your Committee on Tuberculosis and Public Health has met on several occasions. Acting in its advisory capacity to the Florida Tuberculosis and Health Association and also the State Tuberculosis Board, matters pertaining to the proposed state tuberculosis hospital have been discussed. Your Committee has been in full accord with the efforts of the aforementioned organization in their attempts to construct a state tuberculosis hospital. The fact that this project has not yet materialized is not due to any indolence on the part of the proper authorities but to the involved legal technicalities regarding the authority of the State Tuberculosis Board to contract mortgage obligations. A recent decision of the State Supreme Court will necessitate some other approach before our state sanatorium for tuberculous patients becomes a reality.

This Committee recommends a continuation of cooperation of the Florida Medical Association with the State Tuberculosis Board and the State Tuberculosis and Health Association in all further efforts toward obtaining a state tuberculosis sanatorium.

Your Committee sponsored exhibits on tuberculosis in cooperation with the Florida Tuberculosis and Health Association during the graduate short course for physicians held in Gainesville June 24-29, 1935.

All materials used for distribution to physicians, nurses and other professional and lay groups were passed upon by your Committee before distribution to these groups or the public. Members of the Committee have given demonstrations in tuberculin testing and pneumothorax at the request of the Florida Tuberculosis and Health Association and affiliated groups.

The Committee cooperated with the Florida Tuberculosis and Health Association in bringing to Florida Dr. H. W. Hetherington, chief of the Tuberculosis Clinic, Henry Phipps Institute, as the principal speaker at the annual conference of this organization, March 30 and 31, 1936.

M. JAY FLIPSE, Chairman;
J. C. MCSWEEN,
J. MAXEY DELL,
T. Z. CASON,
W. C. BLAKE.

The Committee on Feeble-Minded and Venereal Disease Control was not represented.

The report of the Committee on Maternal Welfare was read by Dr. Homer L. Pearson, as follows:

REPORT OF COMMITTEE ON MATERNAL WELFARE

As you know this committee is a new one, authorized by the House of Delegates at its last meeting in 1935.

The duties of the Committee were not specified, therefore we of the Committee felt that this year we should study the activities of similar committees of other states and then outline for the incoming Committee its duties.

It might not be amiss to give you a brief outline of the conclusions reached by other such committees whose reports we studied. These reports were from New York, New Jersey, Pennsylvania and Georgia, and their conclusions were somewhat as follows:

(1) The average medical student does not receive adequate obstetric training before being permitted to practice.

(2) In many instances our zeal for surgery greatly exceeds our judgment, and as a result there is much too much operative interference.

(3) Too few of us do post-graduate study in obstetrics.

(4) The midwife problem is a real problem.

(5) There is a seeming difference on the part of many physicians to our much too high ma-

ternal mortality and morbidity rate. They as a rule have failed to appreciate that maternal mortality has not been reduced in spite of increased hospitalization, in spite of our aseptic and antiseptic measures and our teaching of prenatal care. They do not seem to realize that the largest quota of deaths is from sepsis and it is followed closely by the toxemia class of deaths, which should be more controllable by intelligent, observing, conscientious physicians.

(6) There is an unwillingness on the part of physicians, generally, to accept the blame for a large portion of maternal deaths which studies have shown to be preventable or controllable.

(7) Failure on the part of many physicians to make use of the knowledge or means available which have proved of value under similar circumstances. In other words, not practicing as good obstetrics as we know.

(8) Lack of appreciation of the laity of the seriousness of pregnancy and labor, or lack of public education.

It is readily seen from the above observations that the fault lies first with the physician and second with the patient herself, and that the causes of maternal deaths are largely preventable or controllable.

Since the blame has been placed on us principally, it is up to us to do something about it, so your committee presents the following program on maternal welfare for your approval:

(1) That the president appoint a committee on maternal welfare, consisting of a chairman and twenty members, in other words, a committee member from each councilor district, the personnel of this committee to be made up of physicians who are particularly interested in obstetrics and maternal welfare, the member in each district to be held responsible for carrying out the program of this committee in his district.

(2) It shall be the duty of the chairman to work out a plan with the Bureau of Vital Statistics, whereby a questionnaire can be sent to the physician who attended each maternal death. The purpose of the questionnaire is to determine more fully the exact cause of death, the condition of the patient during the prenatal period, the amount of prenatal care she received, and the treatment she was receiving at the time of her death. The questionnaire shall be the same as that sent out by the Georgia Committee on Maternal Welfare. The committeeman from each district is to see that the questionnaire is duly filled out and returned to the chairman of the committee.

(3) In a letter accompanying the questionnaire, to the physician, it must be made clear that the questionnaire is in no wise condemnatory, nor criticizing, is entirely impersonal and for the purpose of trying to find the ways and means of reducing maternal mortality, and that to do so we must have his cooperation and will welcome his suggestions.

(4) It shall be the duty of the committeeman of each councilor district to have presented before each county and district medical society of his district, the facts and truths concerning maternal mortality. He must also see that at frequent intervals suitable papers are presented to his societies emphasizing particularly standard methods of treatment for various complications of pregnancy, labor and the puerperium.

(5) This committee shall cooperate in every way with the State Board of Health in order to obtain Federal aid in carrying on this great work.

(6) The Committee shall cooperate with the Committee on Post-Graduate work in order to have as many men as possible attend the lectures in Gainesville each year. They shall also cooperate with Public Relations Committee so that the public may become more educated along these lines.

(7) The chairman should keep in constant touch with like committees of other states and also with the national committee so that the activities of this Committee can be supplemented as the work progresses.

(8) The expenses incurred by this Committee in carrying out its duties shall be paid by the Florida Medical Association.

(9) An annual report shall be presented to the Association at its convention.

(10) To always keep in mind that the only function of this Committee is to study and apply ways and means for reducing maternal mortality.

Homer L. Pearson, Chairman;
Simon E. Driskell,
J. H. Pound,
R. D. Ferguson.

On motion made, seconded and carried, the report of the Committee on Maternal Welfare was unanimously adopted.

The following letter from Dr. D. W. McMillan was read by Dr. Herbert L. Bryans:

"Pensacola, Florida, April 23, 1936.

"Dr. Herbert L. Bryans,
President, Florida Medical Association,
Pensacola, Florida.

"Dear Doctor Bryans:

"Confirming my previous conversation it is my desire to give outright the home that I occupy to the Florida Medical Association to be used as a home by our more unfortunate colleagues who might have reached that age in life where they are physically unable to compete with those more physically qualified and who have not accumulated sufficient worldly goods to maintain themselves in the same position in life and environment as they were accustomed.

"My home is a two-story brick building situated in the center of a city block, which is approximately 2½ acres of land. The house has four bedrooms, four baths, sleeping porch, dining room, breakfast room, kitchen, music room and large attic. Also a two-story garage with servants' quarters above. The house is completely furnished in every detail, the grounds are surrounded by an ornamental iron fence. There is considerable shrubbery and other flowering plants, which are in keeping with the house and its location, situated in one of the finest spots in Pensacola.

"If the occasion should ever arise there is ample room for either enlarging the present building or building six or eight small cottages around the main building.

"My proposition is to donate this property to the State Medical Association provided they will maintain it for the purposes specified above. In view of the fact that I anticipate further improvements which will require about two years to complete, I would respectfully request that you give me a definite answer within twelve months, and if accepted, it will be delivered in twenty-four months from this date.

"Wishing for you one of the best annual meetings that the Florida Medical Association has ever had.

"Yours very truly,

D. W. McMillan, M.D."

Dr. McMillan was introduced by Dr. Hoffman.

It was moved, seconded and carried that a committee be appointed to thoroughly investigate this property and to report its findings at a later date.

Motion by Dr. Jelks that this Association express its gratitude to Dr. McMillan for his generous offer.

Voted and unanimously carried.

Dr. J. Knox Simpson, Chairman, gave a verbal report from the Boat Committee in reply to requests for change in schedule. He announced that the boat would remain in Havana for an additional hour Tuesday night, sailing at 1:00 a. m. instead of 12:00 midnight, and that the program would be carried out as otherwise planned.

There being no further business, the meeting adjourned.

FIRST MEETING OF THE HOUSE OF DELEGATES

The House of Delegates convened at 8:00 p. m. Monday, April 27th, in the Veranda Ballroom, SS. "Florida".

The meeting was called to order by the President, Dr. Herbert L. Bryans.

The following delegates were seated:

DELEGATES

Alachua County Medical Society:
E. H. Andrews
Bay County Medical Society:
W. C. Roberts
Brevard County Medical Society:
T. C. Kenaston
Broward County Medical Society:
Leigh F. Robinson
Columbia County Medical Society:
W. S. Nichols
Dade County Medical Society:
M. J. Flipse
H. A. Barge
Homer Pearson
D. W. Harris
M. E. Threlkeld
H. A. Walker
R. N. Burch
J. E. Hall
R. E. Repass
I. H. Agos
DeSoto-Hardee-Highlands County Medical Society:
C. H. Kirkpatrick
Duval County Medical Society:
James H. Randolph
L. Y. Dyrenforth
Edward Jelks
Ferdinand Richards
E. T. Sellers
K. A. Morris
Escambia County Medical Society:
W. C. Payne
J. M. Hoffman
Hillsborough County Medical Society:
George Cook
George Maner
Jas. L. Estes
W. C. Blake
Jackson County Medical Society:
N. A. Baltzell
Lake County Medical Society:
M. M. Hannum
Lee County Medical Society:
E. Bostelman.
Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society:
J. H. Pound
J. C. Davis
Manatee County Medical Society:
H. Gates
Marion County Medical Society:
J. N. Moore
Orange County Medical Society:
Horace A. Day
J. S. McEwan
W. H. Spiers
Palm Beach County Medical Society:
O. F. Schiffli
L. M. Rozier
Pinellas County Medical Society:
W. M. Davis
O. O. Feaster
W. C. McConnell
A. J. Wood
St. Johns County Medical Society:
V. A. Lockwood

St. Lucie-Okeechobee-Indian River-Martin County Medical Society:
E. B. Hardee
Sarasota County Medical Society:
J. C. Patterson
Seminole County Medical Society:
A. W. Knox
Taylor County Medical Society:
Ralph J. Greene
Volusia County Medical Society:
J. Ralston Wells
L. von Mysenbug
Walton-Okaloosa County Medical Society:
S. E. Stephens
Madison, Monroe, Pasco-Hernando-Citrus, Polk, Putnam and Sumter County Medical Societies were not represented.

The first order of business was the adoption of the minutes of last year's meeting. It was moved and seconded that the minutes be adopted as published in the May, 1935, Journal. Voted and carried.

President Bryans called for the nomination of one delegate and one alternate to the House of Delegates of the American Medical Association for two-year terms.

Dr. Herbert L. Bryans was nominated by Dr. Homer Pearson as a delegate to the A. M. A. for a two-year term, and the nomination duly seconded.

Dr. H. A. Barge was then nominated by Dr. J. E. Hall as a delegate to the A. M. A. for two years. Nomination seconded.

On motion duly seconded and carried the nominations were closed.

Dr. O. O. Feaster was asked to take the Chair. A roll-call vote by secret ballot was requested. Drs. M. J. Flipse and Jos. W. Taylor were named tellers.

Dr. Bryans received the majority of the votes cast and was then declared a delegate to the A. M. A. for a period of two years.

President Bryans returned to the Chair and made the following brief address:

"Gentlemen, I appreciate this honor very much. I will try to represent you in our national organization to the very best of my ability, and give you a complete report at the next annual meeting as to what happens."

Motion was then made by Dr. J. E. Hall that the election of Dr. Bryans as delegate be declared unanimous. Voted and carried. So ordered.

President Bryans called for nominations for an alternate to the A .M. A. for a two-year term, and Dr. Wells nominated Dr. Hendricks of Ft. Lauderdale. Nomination seconded.

On motion duly seconded and carried the nominations were closed and Dr. E. M. Hendricks was named alternate.

The following proposed amendment to the Constitution was read by the Secretary:

That the first sentence of Article VI, Section 2. be amended to read:

"The Association shall hold an annual meeting at a place selected by the outgoing Executive Committee."

Dr. Spiers offered a motion which was duly seconded that this amendment be tabled. Voted and carried.

Motion by Dr. J. E. Hall that the House of Delegates select the meeting place for the 1937 convention, by voting on the invitations presented. Duly seconded and carried.

The next order of business being the presentation of invitations from the County Societies to entertain the convention next year, a cordial invitation was extended by the Pinellas County Society for the Association to go to St. Petersburg.

Motion made, seconded and carried that the invitation from St. Petersburg be accepted.

Motion by Dr. J. E. Hall that the Secretary be instructed to cast a unanimous ballot for St. Petersburg. Voted and carried. So ordered.

A resolution was read by Dr. O. O. Feaster on medical ethics. (*Again read at second meeting of House of Delegates and reproduced in full in proceedings of that meeting.*)

It was moved and seconded that the resolution read by Dr. O. O. Feaster be adopted as an amendment to the By-Laws.

Dr. Sellers expressed the hope that every man would vote in favor of the resolution because it was badly needed.

Discussion of Dr. Blake from Hillsborough County was also in favor of adoption.

Dr. T. W. Harris expressed the willingness of the East Coast Physicians to work with this movement but wanted it clearly differentiated from the Doctors with established practices under legitimate contracts.

Dr. H. A. Day: "If the Florida Medical Association adopts this resolution, it is going to make us clean our own house first. First we had the railroad surgeons, later there was the sawmill physicians and now we have college physicians. It all has a tendency toward socialistic medicine. The State Medical Association has no right

to put any one out of that organization if he belongs to the county society."

Dr. K. A. Morris: "This seems to be a question of medical ethics. The only trouble with medical ethics is that we have not tried them enough. If a thing is right, it is right. If these resolutions are good we will have to clean our own house before we can get this thing started. As Chairman of one of the Ethics Committees I wish to see us endorse this thing one hundred per cent."

Dr. J. E. Hall: "Speaking for the Dade County Medical Society of which I have the honor to be president, I want to say that we are in sympathy with Dr. Blake and the doctors on the West Coast."

Dr. McEwan: "We should all get behind this resolution and give our friendly support to Hillsborough County. Help them to clean house. If we pass this resolution it serves notice on these would-be ethical men in Hillsborough County who want to clean house and haven't the nerve, that we will all support them to the best of our ability."

President Bryans then requested Dr. Turberville, as Chairman of the Committee on Medical Economics, to explain the opinion of his committee on this subject:

Dr. Turberville: "I have had contact with three members of this committee tonight and each of them favored this resolution.

"I have tried to answer this question before, by referring to the State of Alabama. I think we should differentiate between contract practice and list practice. There is a difference. Take the sawmill practice as an example. I am a contract doctor and have been one for many years. But, I am not a list doctor. We want to make a distinction there. Contract practice in certain forms has been found to be for the best. For instance when you are examining for life insurance you are a contract doctor but not a list doctor. You examine the people assigned to you but there is no responsibility. There are other instances where you handle a large group of men in this same capacity. You are then doing a contract practice. And the difference is this. You are not fighting against each other and trying to get the practice for yourself. The idea of this resolution, as I see it, is to protect the legitimate practitioner, in these large practices from the bargaining of doctors for these contract practices. The beginning of state medicine lies behind these large practices. That is also the thing that led to state medicine in Germany and England. Large practices got to be in such deplorable condition that something had to be done. That is where state medicine started. Today all of the large companies are falling into line, one after another. France and England have the best medical laws of any. Germany has the worst. England has had such laws for twenty-five years. France only just a few years."

Dr. Flipse: "I feel that there is not any one of us who is entitled to all of the credit as originator of this resolution. There are certain violations in this resolution. It violates our constitution and it cannot therefore be passed in its present form. Our constitution definitely states that the members of this association shall be members of the component county medical societies. Consequently the next to the last paragraph of the resolution in form violates the constitution in stating that persons shall be subjected to expulsion from the Florida Medical Association. That part of this resolution is entirely unconstitutional, and therefore this resolution cannot be adopted in its present form."

Motion by Dr. Flipse that this resolution be referred back to its originator with instructions to revise it so that it may be in keeping with our constitution, and that it be then resubmitted at a subsequent meeting.

Motion seconded.

A substitute motion offered by Dr. E. W. Harris that the Chair appoint a committee to revise this resolution and report back at this meeting.

Substitute motion seconded, voted and carried.

Dr. Bryans appointed Drs. Feaster, Blake and Flipse to revise the resolution in accordance with the constitution and report back.

Resolutions were read by Dr. W. H. Spiers of Orlando, proposing amendments to By-Laws, concerning councilor districts and appointment of Committees. (*Again read at second meeting of House of Delegates and reproduced in full in proceedings of that meeting*).

President Bryans announced that the resolutions read by Dr. Spiers were offered as amendments to the By-Laws and therefore to be held over until the second meeting of the House of Delegates Wednesday morning.

The following resolution was read by Dr. Edward Jelks.

"That the first part of Chapter VIII, Section

1, be amended to read: 'An assessment of $8.50 per capita on membership of component societies is hereby made the annual dues of the Association; of this amount $1.00 shall be set up as an emergency fund.' "

The discussions which followed strongly favored an increase of $2.50 instead of $1.00 in dues.

Dr. Jelks then amended his resolution to read:

"That the first part of Chapter VIII, Section 1, be amended to read: 'An assessment of $10.00 per capita on membership of component societies is hereby made the annual dues of the Association; of this amount $2.50 shall be set up as an emergency fund.' "

The resolution read by Dr. Jelks, as amended, was held over until the second meeting of the House of Delegates, for action.

Motion duly made, seconded and carried that Dr. David Rose be accorded honorary membership in the Association.

Dr. Richardson read a request for volunteers to visit the hospital in Havana, and the following doctors responded: J. C. Davis, L. von Mysenbug, E. Bostelman, J. H. Randolph and J. H. Pound.

The committee appointed to revise the resolution of Dr. Feaster reported back and the revised resolution on medical ethics was read by Dr. Blake. (*Again read at second meeting of House of Delegates and reproduced in full in proceedings of that meeting.*)

The resolution was held over for final vote at the next meeting of the House of Delegates, Wednesday morning.

It was moved, seconded and carried that the above resolution, if passed, be made a part of the By-Laws of the Association.

There being no further business, on motion, the meeting adjourned.

SECOND GENERAL SESSION

The General Assembly reconvened at 9:00 a. m., Tuesday, April 28th, on board the SS. "Florida", with President Herbert L. Bryans in the Chair.

Meeting called to order.

The following report of the Secretary-Treasurer-Editor and Business Manager was read by Dr. Stewart G. Thompson:

JOINT REPORT OF SECRETARY-TREASURER, EDITOR OF THE JOURNAL, DR. SHALER RICHARDSON, AND BUSINESS MANAGER, DR. STEWART G. THOMPSON

To the President and Members of the Florida Medical Association in Session aboard the SS. "Florida":

GENTLEMEN:

MEMBERSHIP

There was a net increase of 70 paid members in the Association during 1935. For that year the membership was 1,065 as compared with 995 in 1934. The Dade County Medical Society again held first place, having a total of 210 paid members. In addition to being the largest society, this organization held the distinction of having a 100% paid membership. The Duval County Medical Society was second with dues paid for 144 of their 149 members. Hillsboro County Medical Society was third, having a paid membership of 115 and a total membership of 119.

For the calendar year 1935, twenty-one county societies reported 100% of their dues paid. The list which follows indicates the number of reported and paid members, by societies, for 1935.

COUNTY SOCIETY.	Members, 1935	
	Reported	Paid
Dade	210	210
Duval	149	144
Hillsboro	119	115
Pinellas	79	76
Polk	57	57
Orange	53	53
Palm Beach	53	53
Escambia	39	39
Volusia	39	37
Leon, et. al.	34	28
Alachua	25	25
Broward	22	22
Marion	20	20
DeSoto-Hardee-Highlands	19	19
Lake	19	18
Sarasota	14	14
Pasco, et al.	13	13
St. Lucie, et al.	12	12
Jackson	12	11
Manatee	12	9
St. Johns	11	11
Seminole	11	11
Bay	11	10
Columbia	10	10
Lee	10	10
Brevard	9	8
Taylor	7	7
Putnam	7	6
Walton	6	6
Sumter	5	5
Madison	3	3
Monroe	3	3
Individuals	1	0
	1,094	1,065

The number of members dropped in 1935 because of death, removal from the state or failure to pay dues was 37 as compared with 24 for the previous year.

JOURNAL

During the past fiscal year, 15,240 Journals were mailed from the business office. Each month the Journals are delivered to this office and from there mailed to the membership of the Association. There is, therefore, no additional expense to the Association in connection with the mailing of the Journal. Also, the business office is enabled to keep up-to-date its mailing list for members, advertisers and subscribers.

Printing costs have advanced since the last annual meeting and, as a result, there was a slight increase in the printing price of the Journal. This additional cost for printing approximates $25.23 per month.

The Record Company of St. Augustine has printed the Association's Journal for many years and their work has been entirely satisfactory. The Association is, indeed, fortunate in having the services of a printing company which cooperates in keeping down the cost of printing and at the same time turns out such excellent work.

Your Committee on Publication has cooperated wonderfully. Each scientific paper presented for publication must be carefully read and edited by the members of this Committee. The work requires a great deal of time and the members of the Committee, Doctors Walter C. Jones and Herbert E. White, should be highly commended for their generosity in devoting so much time to this important phase of the Association's activities.

FINANCES

The net increase of receipts over disbursements for the past fiscal year was $2,102.19. To keep the Association's finances from going in the "red" this year and to make possible this net increase, it was necessary to take advantage of every means possible to curtail expenses. Purchases of stationery, envelopes, mimeograph paper and other office equipment were made at exceedingly low prices based on large quantities. This was made possible by placing the Association's order with that of the State Board of Health and having separate billings made to the two organizations. This saving in the cost of purchases made a material difference in the office expense during the year.

There was an income from advertising of $3,364.58 as compared with $2,738.06 for the previous year. This represents $626.52, a small increase from this source.

At the last annual meeting held in Ocala, twelve exhibit spaces were sold, representing a total of $640.00. At the Jacksonville annual meeting the previous year, seventeen exhibit spaces were sold, representing a total of $770.00. The sale of exhibit space was not pushed at the Ocala meeting as the headquarters hotel did not have facilities for more than twelve exhibitors. The sale of exhibit spaces has made a small increase in the revenue of the Association. The exhibitors have been courteous and very loyal in their support during conventions.

IN THE OFFICE

The work in the business office has steadily increased from year to year and especially during the past year. With this increase in work an additional expense has necessarily followed. A number of your important committees have increased their activities. This increase in committee activities indicates a constructive growth and is very important to the life of the Association.

The Legislative Committee secured through the central office mimeographed copies of bills to be presented to the Legislature. Your Committee on Public Relations has been very active and has turned considerable work over to the business office in connection with the advertising of broadcasts, printing of reprints, etc. The Executive Committee has notified the membership on several points of interest which required a large number of circular letters. The Committee on Medical Economics has also used the central office in disseminating information concerning their problems. The Inter-relationship Committee has had a number of mimeographed letters run. The Committee on Boat Trip has used the central office for disseminating information concerning the Sixty-third Annual Convention. This Committee has been very active and has circularized the membership numerous times in order that the attendance at the convention might well represent the entire membership. The Committee on Scientific Work circularized the entire membership for papers to be presented at the scientific assemblies and follow-up letters were prepared through the central office for this Committee. Notices of committee meetings, pre-convention meeting and other special meet-

ings have been announced through the business office. During the past year, 6,035 first-class letters were typed and mailed in addition to thousands of sheets mimeographed. A representative from your business office met with the various committees when requested.

It is not our intention to burden you with details and mention has been made of only some of the activities to give you an idea of the work carried on in the central office.

The books and records of the Association are open to our members and we will be glad to answer inquiries of any nature. The books have been audited by Ford, Boyd & Colley, and a certification thereof is incorporated in the statements which follow.

Respectfully submitted,

SHALER RICHARDSON,
STEWART G. THOMPSON.

FORD, BOYD & COLLEY
CERTIFIED PUBLIC ACCOUNTANTS

Jacksonville, Fla., April 23, 1936.

Dr. Shaler Richardson,
Treasurer,
Florida Medical Association, Inc.,
Jacksonville, Florida.

DEAR SIR:

We have examined the attached statements of Cash Receipts and Disbursements of Florida Medical Association, Incorporated, for the period begun April 23, 1935, and ended April 13, 1936, both inclusive. These statements have been prepared by Dr. S. G. Thompson, Business Manager of Florida Medical Association, Incorporated, and the Florida Medical Journal, and correctly reflect the total amounts received and disbursed as shown by the books.

In accordance with your instructions, we have checked the total of the collections shown by the statements with the corresponding entries in the cash journal; the additions of the cash journal were checked and a trial balance prepared as of April 13, 1936.

Bank accounts were reconciled with bank statements and pass books and confirmations were obtained from the bankers.

As we do not have access to the records of the various County Societies for the purpose of checking the remittances of dues, attention is directed to Exhibits D and F which give details as to this matter. The inspection of these exhibits by the officers of the respective societies will enable them to verify the correctness of the remittances shown.

Income from Journal advertising was verified substantially by comparison with a statement of the contracts with advertisers.

The ten United States Treasury Bonds, par value $1,000.00 each, were verified by us with the Atlantic National Bank.

Yours very truly,

FORD, BOYD & COLLEY.

CONSOLIDATED CASH STATEMENT
April 23, 1935, through April 13, 1936

Receipts		
Cash in Bank, April 23, 1935		$16,310.57
Dues Collected (Exhibit "D")	$ 8,160.00	
Earnings from Advertising (Exhibit "E")	3,364.58	
Subscription and Miscellaneous Sale of Journal	18.90	
Bonus from Cooperative Medical Advertising Bureau	170.09	
Reprints—L. & N. R. R. Co.	4.02	
Interest on Savings and Investment	561.94	
Earnings—Technical Exhibits (Exhibit "C")	545.00	12,824.53
Total Cash to be Accounted for		$29,135.10
Disbursements		
General Fund Expenses (Exhibit "A")	$ 4,076.80	
Journal Expenses (Exhibit "B")	4,956.98	
Technical Exhibit Expenses (Exhibit "C") $117.45		
To Entertaining Society 237.00	354.45	
Committee Expenses	969.11	
Furniture and Fixtures	30.50	
Library	327.55	
Federal Tax	6.95	10,722.34
Balance in Bank, April 13, 1936		$18,412.76

EXHIBIT "A"
CASH STATEMENT—GENERAL FUND
April 23, 1935, through April 13, 1936

Receipts		
Cash as per last audit		$15,629.75
Back dues Collected (Exhibit "D")	$1,410.00	
Current dues Collected (Exhibit "D")	6,750.00	8,160.00
Interest on Savings and Investment		561.94
Total Cash to be Accounted for		$24,351.69
Disbursements		
Postage and Supplies	$ 261.90	
Telephone and Telegraph	145.92	
Salaries	3,078.26	
Convention Expenses	103.72	
Office Rent	180.00	
Legal Counsel	100.00	
Auditing Expense	12.50	
Messenger Service	5.50	
Bond of Treasurer	18.75	
Custody of Bonds	10.00	
Incidental Expense	22.88	
Transportation Expenses, A. M. A. Delegates	135.57	
Bank Exchange	1.80	$4,076.80
Committees:		
Post-Graduate Course	500.90	
Legislative	450.91	
Boat Trip	12.25	
Scientific Work	3.75	
Inter-Relationship	1.30	969.11
Furniture and Fixtures		30.50
Library		327.55
Federal Tax		6.95
To Journal Fund (Difference between $3.00 per member and cost of Journal)	1,399.39	6,810.30
Cash Balance		$17,541.39

EXHIBIT "B"
CASH STATEMENT—JOURNAL FUND
April 23, 1935, through April 13, 1936

Receipts

As per last audit		0.00
Earnings from Advertising (Exhibit "E")	$3,364.58	
Subscription and Miscellaneous Sale of Journal	18.90	
Bonus from Cooperative Med. Adv. Bureau	170.09	
Reprints—L. & N. R. R. Co.	4.02	
From General Fund	1,399.39	
To be Accounted for		$4,956.98

Disbursements

Postage and Supplies	$ 212.32	
Printing of Journal and Electrotypes	3,027.98	
Telephone and Telegraph	73.23	
Salaries	1,580.35	
Auditing Expense	12.50	
Bond of Treasurer	18.75	
Drayage	15.00	
Messenger Service	8.45	
Incidental Expense	8.40	4,956.98
Cash Balance		$ 0.00

EXHIBIT "C"
CASH STATEMENT—EXHIBIT FUND
April 23, 1935, through April 13, 1936

Receipts

Cash as per last audit	$ 680.82	
Earnings from Technical Exhibits	545.00	
Total Cash to be Accounted for		$1,225.82

Disbursements

Salaries	$ 3.87		
Convention Expense	65.63		
Sign Painting, etc.	43.00		
Electrotype	4.95	$117.45	
To Entertaining Society (Marion County Medical Society)		237.00	354.45
Cash Balance			$ 871.37

EXHIBIT "E"
EARNINGS FROM ADVERTISING
April 23, 1935, through April 13, 1936

May, 1935	$ 174.02
June	149.53
July	224.26
August	377.74
September	254.05
October	293.61
November	393.85
December	266.51
January, 1936	235.34
February	323.58
March	285.96
April	386.13
Total	$3,364.58

EXHIBIT "D"
DUES COLLECTED APRIL 23, 1935, THROUGH APRIL 13, 1936

Name of Society	Total Members	No. Paid Members	No. in Arrears	1936 Dues Collected	Back Dues Collected
Alachua	26	23	3	$ 165.00	$ 52.50
Bay	12	9	3	60.00	15.00
Brevard	9	3	6	15.00	30.00
Broward	24	24	0	172.50	15.00
Columbia	9	8	1	52.50	7.50
Dade	221	191	30	1,425.00	292.50
DeSoto-Hardee-Highlands	20	7	13	45.00	.....
Duval	145	123	22	915.00	405.00
Escambia	41	22	19	157.50	195.00
Hillsboro	116	102	14	757.50	75.00
Individuals	2	0	2	.....	.....
Jackson	12	8	4	52.50	7.50
Lake	15	15	0	105.00	.....
Lee	10	10	0	67.50	7.50
Leon-Gadsden-Liberty-Wakulla-Jefferson	32	21	11	150.00	7.50
Madison	3	3	0	22.50	.....
Manatee	11	11	0	75.00	.....
Marion	22	22	0	157.50	7.50
Monroe	4	4	0	22.50	15.00
Orange	57	53	4	390.00	22.50
Palm Beach	55	50	5	367.50	7.50
Pasco-Hernando-Citrus	13	8	5	52.50	.....
Pinellas	81	79	2	585.00	37.50
Polk	59	31	28	225.00	37.50
Putnam	9	9	0	60.00	15.00
St. Johns	10	9	1	60.00	.....
St. Lucie-Okeechobee-Indian River-Martin	12	8	4	52.50	75.00
Sarasota	16	16	0	112.50	.....
Seminole	12	12	0	82.50	7.50
Sumter	4	4	0	30.00	.....
Taylor	6	5	1	30.00	7.50
Volusia	38	34	4	247.50	67.50
Walton-Okaloosa	6	6	0	37.50	.....
Totals	1,112	930	182	$6,750.00	$1,410.00
				1,410.00 Back Dues Collected	
				$8,160.00 Total Dues Collected	

EXHIBIT "F"
NAMES OF MEMBERS DROPPED BY REASON OF REMOVAL, NON-PAYMENT OF DUES, ETC.
April 23, 1935, through April 13, 1936

Name and Address	Dues Not Paid 1935	1936
BAY COUNTY MEDICAL SOCIETY:		
McClane, John W., Panama City	7.50	7.50
Roberts, W. C., Panama City	7.50*	....
BREVARD COUNTY MEDICAL SOCIETY:		
Hicks, I. K., Melbourne	7.50	7.50
DADE COUNTY MEDICAL SOCIETY:		
DeVilbiss, Lydia A., Miami	7.50	....
Keely, J., Miami	7.50	....
Newell, C. E., Miami	7.50	....
Sinclair, J. A. B., Miami	7.50	....
DUVAL COUNTY MEDICAL SOCIETY:		
Brillhart, H. L., Jacksonville	7.50	7.50
Enneis, F. B., Jacksonville	7.50	7.50
Ives, Harold A., Jacksonville	7.50	7.50
Lamb, Robert J., So. Jacksonville	7.50	7.50
Lipscomb, T. H., Jacksonville	7.50	7.50
Schneider, David, Jacksonville	7.50	....
Thompson, T. C., Jacksonville	7.50	7.50
HILLSBORO COUNTY MEDICAL SOCIETY:		
Bergman, Sam, Tampa	7.50	....
Evans, Harry C., Tampa	7.50	....
Fluker, Carl B., Tampa	7.50	....
McRae, E. H., Tampa	7.50	....
INDIVIDUALS:		
Chappell, F. V., Marianna	7.50	....*
Alexander, Morris J., Punta Gorda	7.50	....
JACKSON COUNTY MEDICAL SOCIETY:		
Cline, Daniel E., Marianna	7.50	7.50
LAKE COUNTY MEDICAL SOCIETY:		
Izlar, A. L., Clermont	7.50	....
LEON-GADSDEN-LIBERTY-WAKULLA-JEFFERSON COUNTY MEDICAL SOCIETY:		
Gardner, O. W., Greensboro	7.50	....
Glover, George B., Monticello	7.50	....
Harper, J. Andrew, Crawfordville	7.50	....
Murrow, J. S., Apalachicola	7.50	....
Walker, William H., Lamont	7.50	....
Wilensky, M. C., New Orleans	7.50	....
MANATEE COUNTY MEDICAL SOCIETY:		
English, A. Q., Palmetto	7.50	....
Harrison, M. M., Bradenton	7.50	....*
Stebbins, A. L., Punta Gorda	7.50	....
ORANGE COUNTY MEDICAL SOCIETY:		
Brinson, Haynes, Kissimmee	....	7.50
Geiger, H. St. C., Kissimmee	7.50	....
PINELLAS COUNTY MEDICAL SOCIETY:		
Burnette, Elmer W., Tarpon Springs	7.50	....
Burns, A. B., Tarpon Springs	7.50	....
Hooper, Clara A., Glen Arbor, Mich.	7.50	....
POLK COUNTY MEDICAL SOCIETY:		
King, William W., Lakeland	7.50	....
PUTNAM COUNTY MEDICAL SOCIETY:		
Rosborough, D. Y., Palatka	7.50	....*
ST. LUCIE-OKEECHOBEE-INDIAN RIVER-MARTIN COUNTY MEDICAL SOCIETY:		
Glidden, C. H., Ft. Pierce	7.50	....
Lingo, M. J., Panama City	7.50	....*
SARASOTA COUNTY MEDICAL SOCIETY:		
Burger, Benjamin H., Chicago, Ill.	7.50	....
VOLUSIA COUNTY MEDICAL SOCIETY:		
Davis, C. W., Daytona Beach	7.50	7.50
Jones, C. B., New Smyrna	7.50	....*
	$315.00	$ 82.50
Dues of Secretaries	15.00	225.00
	330.00	307.50
		330.00
Total		$637.50

*Reinstated.

ASSETS AND LIABILITIES
April 13, 1936

Assets

Cash in Bank	$ 6,035.52
General Fund—Accounts Receivable	1,365.00
Furniture & Fixtures (less depreciation)	262.02
Library	467.45
Stationery Inventory	116.89
Savings—Atlantic National Bank	4,040.00
Barnett National Bank	8,337.24
Investment (Treasury Bonds)	10,178.13
	$30,802.25

Liabilities

Journal—Accounts Receivable	$ 59.45
Capital Account	30,742.80
	$30,802.25

Upon motion duly made and seconded the Association voted unanimously to accept the report as read.

The following report of the Executive Committee was read by Dr. Edward Jelks:

REPORT OF THE EXECUTIVE COMMITTEE

The Executive Committee of the Florida Medical Association, which acted as your Agent in the interval since the last meeting in Ocala and this one today, begs to present to you the following report:

On May 15th, at the close of the Ocala Convention, the Executive Committee held its first meeting. This Committee was composed of one member of the Association from each of the State Districts created by the House of Delegates. They chose Dr. T. H. Bates of Lake City as Chairman pro tem., selected a permanent chairman, and elected Dr. Stewart Thompson Business Manager for the ensuing year.

Two subsequent meetings were held, one in Jacksonville on Sept. 26, 1935, and another in Jacksonville on February 23, 1936.

By request of the President, members of the Executive Committee have met repeatedly with other committees. This action has been true especially in the case of the Committee on Medical Economics.

At the meeting on Feb. 23rd, the Committee received notification from Mr. Dan U. Wilder, Representative of the P. & O. Steamship Company, that they were sufficiently satisfied with the number of reservations to proceed with the arranging of the boat trip. April 27, 28, and 29 were set as the dates for the 1936 meeting.

In response to the wish of the State Health Officer, Dr. W. A. McPhaul, the Executive Committee requested the President of the Association to appoint an Advisory Committee to work with the State Board of Health, and suggested that this Committee be composed of the three recent Past Presidents of the Association.

During the year, Dr. J. S. Turberville, Chairman of the Committee on Medical Economics, has sought repeatedly, advice and cooperation of the Executive Committee. On his suggestion, it was recommended first, "that the Florida Medical Association request through the U. S. Senators, that the Employees Compensation Commission, in providing medical care to persons injured by accident causing damage or harm to the physical structure of the body permit persons so injured when injury occurs in places of their residence, to select physicians or other professional workers rendering such care." It was further recommended that "the Committee on Medical Economics have the power to act on rates submitted for workman's compensation insurance, provided each member of the Executive Committee is notified by letter before decision on the rates is final."

Dr. Turberville presented an outline of recommendations for the professiona! handling of patients on government relief. It was based largely on the so-called New Jersey plan. The Committee adopted in principle Dr. Turberville's recommendations.

The Committee has received credentials of two doctors who have been members of the Florida Medical Association thirty-five years or longer. In accordance with the Constitution, such a length of membership entitles them to Life Membership. The names of the two new life members are:

Dr. Thomas S. Anderson, Live Oak
Dr. Robert H. McGinnis, Jacksonville

Dr. P. M. Lewis, of Orlando, was granted Honorary Membership.

The fiscal activities of the Committee are as follows:

1. It received from the Business Office a working budget for the ensuing year of $9,825.00. This was a slight increase over that of the previous year due to an estimated greater printing cost, and expense incident to various committee activities.
2. An item of expense presented by Past President, Dr. Homer Pearson, of $38.52, covering postage in connection with his activities as president was approved for payment. It was agreed that traveling expenses of a president shall not be paid by the Association.
3. A request for the refund of certain monies expended by the Dade County Medical Society for the prosecution of improper practitioners was not granted, for the reason that this matter had not been handled in the manner which the House of Delegates had established for aiding counties incurring such expense. The resolution is that the State Association will match with a County Society an amount up to $200.00, not to exceed 50% of the state dues paid by the society that year, provided a request is filed with the Treasurer before the monies are expended.
4. The sum of $150.00 was allotted to the Chairman of the Legislative Committee for redrafting medical bills, mimeographing and stenographic services in preparation for the coming session of the Legislature.

Respectfully submitted,

Edward Jelks, Chairman;
Henry E. Palmer,
Gilbert S. Osincup,
Roy J. Holmes,
Thomas H. Bates,
Eugene S. Gilmer.

It was moved and seconded that the report of the Executive Committee be accepted as read. Voted and carried.

The report of Council was not read by Dr. McDuffee as it had been presented at the pre-convention meeting and reports from the various districts have been printed in the Journal.

Dr. Herbert L. Bryans of Pensacola read his Presidential Address.

It was moved and seconded that Dr. O. O. Feaster take the Chair during the presentation of the following motion. Voted and carried.

So ordered.

Motion by Dr. J. C. Davis, seconded by Dr. Patterson, endorsed by Dr. Wells, that the recommendations contained in Dr. Bryans' address be officially adopted.

Substitute motion offered by Dr. Flipse that this report be received and that a committee be appointed to investigate the feasibility and order of adoption of the various recommendations contained in the address of the retiring President.

Substitute motion accepted by Dr. Davis.

Seconded.

Dr. Wells offered an amendment to the substitute motion of Dr. Flipse, that no new committee be formed for this purpose but that it be placed in the hands of one of the regular committees, to be chosen by the President.

It was moved, seconded and carried that the above substitute motion be adopted as amended.

There being no unfinished business, the meeting adjourned.

SECOND SCIENTIFIC ASSEMBLY

The Scientific Assembly reconvened at 10:30 a. m., Tuesday, April 28th, with Dr. Leigh F. Robinson presiding.

The following papers were read and discussed:

5. "Treatment of Eye Diseases by the General Practitioner", Ralph E. Russell, Ocala.
6. "Progress Toward Lessening Maternal Morbidity and Mortality", W. C. Roberts, Panama City.
7. "Management of Peptic Ulcer", P. B. Welch, Miami.

SECOND MEETING OF THE HOUSE OF DELEGATES

The second meeting of the House of Delegates convened at 9:00 a. m. Wednesday, April 29th, in the veranda ballroom, SS. "Florida". President Bryans presided.

The following delegates answered to roll-call:

DELEGATES

Alachua County Medical Society:
E. H. Andrews
Bay County Medical Society:
W. C. Roberts
Brevard County Medical Society:
T. C. Kenaston
Dade County Medical Society:
M. J. Flipse
H. A. Barge
Homer Pearson
D. W. Harris
M. E. Threlkeld
H. A. Walker
J. E. Hall
R. E. Repass
I. H. Agos
DeSoto-Hardee-Highlands County Medical Society:
C. H. Kirkpatrick
Duval County Medical Society:
James H. Randolph
L. Y. Dyrenforth
Edward Jelks
Ferdinand Richards
E. T. Sellers
Escambia County Medical Society:
W. C. Payne
J. M. Hoffman
Hillsboro County Medical Society:
George Cook
George Maner
W. C. Blake
Jackson County Medical Society:
N. A. Baltzell
Leon-Gadsden-Liberty-Wakulla-Jefferson County Medical Society:
J. H. Pound
J. C. Davis
Manatee County Medical Society:
H. Gates
Marion County Medical Society:
J. N. Moore
Orange County Medical Society:
Horace A. Day
Palm Beach County Medical Society:
L. M. Rozier
Pinellas County Medical Society:
W. M. Davis
O. O. Feaster
W. C. McConnell
A. J. Wood
St. Johns County Medical Society:
V. A. Lockwood
St. Lucie-Okeechobee-Indian River-Martin County Medical Society:
E. B. Hardee
Sarasota County Medical Society:
J. C. Patterson
Taylor County Medical Society:
Ralph J. Greene

Broward, Columbia, Lake, Lee, Madison, Monroe, Pasco-Hernando-Citrus, Polk, Putnam, Seminole, Sumter, Volusia and Walton-Okaloosa County Medical Societies were not represented.

The resolution read by Dr. Spiers at the first meeting of the House of Delegates, proposing amendments to By-Laws concerning councilor districts and appointment of committees, was again read by Dr. Feaster.

Motion by Dr. Jelks that the proposed amendment to the By-Laws, as outlined in the resolution, be adopted.

On motion duly made, seconded and unanimously carried the amendment was ordered changed by taking Brevard County from District No. 10 and including it in District No. 9.

An amendment was offered by Dr. Flipse that the duties of the committee on Maternal Welfare

shall be such duties as usually fall upon such a committee.

Amendment of Dr. Flipse seconded by Dr. Pearson and unanimously carried.

The following resolution of Dr. Spiers, as amended, was voted and unanimously carried:

Section 1, Chapter VI, of the By-Laws, relative to the Council, shall be amended to read as follows:

"The Council shall consist of one Councilor from each of the following districts: *Councilor District No. 1,* comprising the following counties: Escambia, Santa Rosa, Okaloosa, Walton, Holmes, Washington, and Bay. *Councilor District No. 2,* comprising the following counties: Jackson, Calhoun, Gulf, Gadsden, Liberty, Franklin, Leon, Wakulla, and Jefferson. *Councilor District No. 3,* comprising the following counties: Madison, Taylor, Hamilton, Suwannee, Lafayette, Columbia, Dixie and Baker. *Councilor District No. 4,* comprising the following counties: Alachua, Marion, Levy, Citrus, Sumter, Hernando, Pasco, Gilchrist, Bradford and Union. *Councilor District No. 5,* comprising the following counties: Duval, Nassau, Clay, and St. Johns. *Councilor District No. 6,* comprising the following counties: Volusia, Flagler, and Putnam. *Councilor District No. 7,* comprising the following counties: Hillsboro, Pinellas, Manatee, and Sarasoto. *Councilor District No. 8,* comprising the following counties: Polk, Hardee, DeSoto, Highlands, Charlotte, Lee, Glades, Hendry, and Collier. *Councilor District No. 9,* comprising the following counties: Lake, Orange, Osceola, Brevard and Seminole. *Councilor District No. 10,* comprising the following counties: Indian River, Okeechobee, St. Lucie, and Martin. *Councilor District No. 11,* comprising the following counties: Palm Beach and Broward. *Councilor District No. 12,* comprising the following counties: Dade and Monroe.

"Upon the adoption of this amendment, the incoming President shall appoint one Councilor for each district, six for one year and six for two years, and thereafter they shall be appointed for two years as the terms expire. The Councilors shall meet immediately after the adjournment of the annual session and elect their Chairman and a Secretary, and the latter shall keep a record of the proceedings. The Council shall, through its Chairman, make an annual report to the first session of the House of Delegates."

First paragraph of Section 1, Chapter VII of the By-Laws, shall be amended to read as follows:

"Regular Committees shall be the Executive Committee (or may be called the Board of Governors) (Sec. 2). A Committee on Scientific Work (Sec. 3); a Committee on Legislation and Public Policy (Sec. 4); a Committee on Publication (Sec. 5); a Committee on Arrangements (Sec. 6); a Committee on Medical Education and Hospitals (Sec. 7); a Committee on Public Relations (Sec. 8); a Committee on Necrology (Sec. 9); a Committee on Medical Post-Graduate Course (Sec. 10); a Committee on Cancer Control (Sec. 11); a Committee on Medical Economics (Sec. 12); Inter-relationship Committee (to work with similar committees from allied professions—dentists, druggists and nurses) (Sec. 13); a Committee on Tuberculosis and Public Health (Sec. 14); a Committee on State Controlled Medical Institutions (Florida State Hospital and Florida Farm Colony) (Sec. 15); a Committee on Maternal Welfare (Sec. 16); and an Advisory Committee to the Woman's Auxiliary (Sec. 17). They shall be appointed by the President as hereinafter prescribed."

Section 7 shall be amended to read as follows:

"The Committee on Medical Education and Hospitals shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the annual session and elect its Chairman. This Committee shall serve in this State for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education."

Section 8 shall be added to include a Committee on Public Relations and shall read as follows:

"The Committee on Public Relations shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the annual session and elect its Chairman. The duties of this Committee shall be to promote friendly relations between this Association and the public, to encourage the propagation of proper medical information to the public, either by publication, radio broadcasts, or talks before community gatherings, the same being censored or controlled by the Florida Medical Association or its component societies."

Section 9 shall be added to include the Committee on Necrology and shall read as follows:

"The Committee on Necrology shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the annual session and elect its Chairman. This Committee shall see that a record and biographical sketch of all deceased members is properly recorded in the annals of the Florida Medical Association, and that suitable resolutions are published in its Journal."

Section 10 shall be added to include the Medical Post-Graduate Course Committee, and shall read as follows:

"The Committee on the Medical Post-Graduate Course shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the annual session and elect its Chairman. This Committee shall confer with the offices of the University of Florida and arrange the schedule of a one-week Post-Graduate course, to be held annually at the University of Florida at Gainesville. They shall have the power to select the Faculty from outstanding medical educators in the United States and make other arrangements necessary for its proper conduction, such as the time, various courses, and the fees to be charged."

Section 11 shall be added to include the Cancer Control Committee and shall read as follows:

"The Committee on Cancer Control shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the annual session and elect its Chairman. This Committee shall cooperate with the Dr. John Gorrie Memorial Foundation and the Council on Cancer Control of the American Medical Association."

Section 12 shall be added to include a Committee on Medical Economics and shall read as follows:

"The Committee on Medical Economics shall consist of six members, one from each district, to be appointed

by the President. Upon the adoption of this amendment, the President shall appoint six members, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the annual session and elect its Chairman. This Committee shall obtain all information relative to medical economic conditions in this State in general."

Section 13 shall be added to include a Committee on Inter-relationship and shall read as follows:

"The Committee on Inter-relationship shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the annual session and elect its Chairman. This Committee shall work with like committees from allied professions — as dentists, pharmacists, and nurses—to provide a medium for discussing and taking concerted action on matters of common interest to these allied professions."

Section 14 shall be added to include a Committee on Tuberculosis and Public Health, and shall read as follows:

"The Committee on Tuberculosis and Public Health shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the annual session and elect its Chairman. This Committee shall cooperate with the Florida Tuberculosis Association."

Section 15 shall be added to include a Committee on Florida State Medical Institutions and shall read as follows:

"The Committee on Florida State Medical Institutions shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the annual session and elect its Chairman. This Committee shall investigate the medical personnel and the medical requirements of all State or public institutions and recommend such changes and improvements as they deem necessary for the most efficient operation of such institutions."

Section 16 shall be added to include a Committee on Maternal Welfare and shall read as follows:

"The Committee on Maternal Welfare shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the annual session and elect its Chairman. The duties of this Committee shall be such as usually fall upon such a committee."

Section 17 shall be added to include an Advisory Committee to the Woman's Auxiliary and shall read as follows:

"The Advisory Committee to the Woman's Auxiliary shall consist of six members, one from each district, to be appointed by the President. Upon the adoption of this amendment, the President shall appoint six members as designated above, two for one year, two for two years, and two for three years, and thereinafter they shall be appointed for three years as the terms expire. This Committee shall meet immediately after the adjournment of the annual session and elect its Chairman. This Committee shall advise the Woman's Auxiliary on medical and ethical subjects pertaining to their activities."

Section 18 shall be added pertaining to reports of the Committees and shall read as follows:

"Each Committee shall have a report of its activities to submit to the annual Pre-Convention Meeting, and shall make its final report to the House of Delegates at its first annual meeting. All reports of committees named in this chapter must be approved by the House of Delegates."

Motion by Dr. Barge that the order of business be changed to take up the resolution of the Hillsboro County Society.

Voted and carried.

The revised resolution on medical ethics was again read by Dr. Blake.

Motion by Dr. Pearson to adopt the amendment to the By-Laws on medical ethics.

Seconded.

Discussion.

Question as to how this amendment would affect contract practice with the CCC camps.

Dr. Flipse: "I believe that I can answer that question. A protective measure is thrown about honest contract practice so that such individuals as are engaged in what we may call honest contract practice would be unaffected. Such items will not be censored by the Executive Committee of the Florida Medical Association. In working up this particular resolution it became obvious at once that certain very extensive contract practices were entirely ethical, for the welfare of both doctor and patient as well as beneficial to the medical profession and medical association of the state. There is, however, another type of contract practice which is dishonest and unethical. Consequently this protective measure is thrown about the individual by submitting this question to the State Executive Committee and then referring the matter back to the local county society of which the doctor is a member. We will not be censored as long as our contract practice remains ethical. But this resolution will give teeth to the ethical code and permit us to strike directly at that type of contract practice which we recognize as a discredit to the medical profession."

The question was called for and by unanimous vote the following amendment was adopted as a part of the by-laws:

Whereas, The rules of conduct as set forth in Chapter IX of the Florida Medical Association, Incorporated, are: "The principles set forth in the Code of Ethics of the American Medical Association shall

govern the conduct of members in their relation to each other and to the public," and,

Whereas, There have sprung up among us various mutual aid societies which render or promise to render medical service for a specified sum, and,

Whereas, These societies actively solicit patients and hire physicians at a fixed rate per month or per patient and thus prevent the free choice of a physician by their clientele, and,

Whereas, This practice is a direct violation of the principles laid down in the Code of Ethics of the American Medical Association, and,

Whereas, This practice constitutes unfair competition and is detrimental to the progress of medical science,

THEREFORE, BE IT RESOLVED:

1. That the poverty of a patient and the mutual professional obligation of physicians should command the gratuitous services of a physician. But endowed institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, have no claim upon physicians for unremunerated services.
2. That it is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession. By the term "contract practice" as applied to medicine is meant the carrying out of an agreement between a physician or a group of physicians, as principals or agents, and a corporation, organization or individual, to furnish partial or full medical services to a group or class of individuals for a definite sum or a fixed rate per capita. Specifically, contract practice is unethical: (1) When there is solicitation of patients, directly or indirectly. (2) When there is underbidding to secure the contract. (3) When the compensation is inadequate to assure good medical service. (4) When there is interference with reasonable competition in a community. (5) When free choice of a physician is prevented. (6) When the conditions of employment make it impossible to render adequate service to the patients. (7) When the contract because of any of its provisions or practical results is contrary to sound public policy.
3. That when a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, it is unethical to give or to receive a commission by whatever term it may be called or under any guise or pretex whatsoever.
4. That it is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy. It is specifically understood that this does not apply to interns devoting their full time to hospital practice.

BE IT FURTHER RESOLVED: That any member violating any of the provisions of this resolution shall be reported to the Executive Committee of the Florida Medical Association, Inc. It shall be the duty of the Executive Committee to investigate such charges and hear the defense of the members so charged. If the charges be sustained, the Executive Committee shall then recommend to the component medical society of which the charged physician is a member such disciplinary measures as are provided in the By-Laws of the component medical society. If further action seems necessary the Executive Committee has the power to report its recommendations to the House of Delegates of the Florida Medical Association, Inc., for such further disciplinary measures as are provided in the Constitution and By-Laws of the Florida Medical Association, Inc.

BE IT FURTHER RESOLVED: That upon the passage of this resolution it shall immediately become a part of the By-laws of the Florida Medical Association, Incorporated.

The resolution to increase dues $2.50, read at the first meeting of the House of Delegates, was again read by Dr. Jelks:

"That the first part of Chapter VIII, Section 1, be amended to read: 'An assessment of $10.00 per capita on membership of component societies is hereby made the annual dues of the Association; of this amount $2.50 shall be set up as an emergency fund.' "

Seconded.

Discussion.

Dr. Barge: "I feel that Dade County has a much better plan. That is for the big counties to go into their own pockets. They are the ones interested in quacks. In the small counties the quacks starve to death. If the big counties want to have this fund, we think they should each put in $500.00. Dade County will back it up with $750.00 if Duval and Hillsboro counties will pay $500.00 each, and the smaller counties $250.00 and the smallest counties in proportion to their size. That would be $3,250.00 all told. If we raise the dues at this time we will get a reaction that we don't want. We do not want the members of the small counties discouraged at this time. What we want is their friendship. So I think this plan of Dade County should be considered first."

Motion by Dr. Barge that the above resolution be tabled until the large counties could be consulted on the Dade County plan. Seconded.

Motion of Dr. Barge voted and lost.

Dr. W. C. Roberts of Bay County: "In defense of the small town doctors: They will be glad to pay $10.00 if they get something more than the Journal. They will want to feel that they, too, helped to secure this legislation."

Resolution to increase annual dues to $10.00 voted and unanimously carried.

Motion by Dr. Flipse:

"I move you that the Secretary be instructed to correspond with the secretaries of all component medical societies and obtain from them a copy of their by-laws and constitution to file

in the office of the Florida Medical Association for reference.

"The purpose of this motion is to permit the executive committee to determine what facilities there are in the By-Laws and constitution of the component medical societies, so that the amendment previously voted regarding the question of referring individuals who have been charged with contract practice back to their component medical society, may be thoroughly understood by the executive committee. The previous amendment arranged for the executive committee to hear charges and then refer the man back to his component medical society for such discipline as is provided in the By-Laws of the county medical society of which that individual is a member. It will be necessary, therefore, for the executive committee to know what the By-Laws are in each component medical society."

Dr. Flipse's motion seconded, voted and unanimously carried.

Motion by Dr. Barge that the Treasurer of the Florida Medical Association hold in readiness $5,000.00 for the use of the Legislative Committee when they need it, this amount to be considered as a loan and the treasury reimbursed from the increase in dues when received.

Seconded, voted and carried.

So ordered.

Meeting adjourned.

THIRD SCIENTIFIC ASSEMBLY

The Third Scientific Assembly was held Wednesday, April 29th, 10:00 a. m., Dr. Leigh F. Robinson presiding.

The following papers were read and discussed:

8. "The Systolic Murmer: Its Interpretation", S. Marion Salley, Miami.
9. "The Role of Sinusitis in the Production of Cough", Joseph W. Taylor, Tampa.
10. "Trigeminal Neuralgia", H. Hamilton Cooke, Miami.
11. "Brain Surgery and Epilepsy", J. G. Lyerly, Jacksonville.
12. "The Value of Skeletal Traction, Especially in Fractures About Joints", Prescott Le Breton, St. Petersburg.

THIRD GENERAL SESSION

The General Session of the Florida Medical Association reconvened at 12:00 noon, April 29th, on board the SS. "Florida," with President Herbert L. Bryans in the Chair.

Meeting called to order.

Motion by Dr. Ira that the Secretary be instructed to write a letter from this body to Walter Bauer, National Publishing Company, New York, and Dr. Maurice Fishbein, 535 N. Dearborn St., Chicago, showing our appreciation of their efforts along the line of Health Education.

Voted and carried. So ordered.

The following resolution was read by Dr. J. Knox Simpson:

"Whereas, we are just completing one of the most pleasant and successful meetings we have ever had, and,

"Whereas, the officials and employees of the P. & O. Steamship Co., in general, and the Passenger Agent, Mr. Austin Williamson, in particular, in the capacity of hosts, have been constantly on the alert in their efforts to insure the success of our meeting, beginning with the detailed preliminary arrangements which began with the inception of the trip last May and continuing to its completion,

"THEREFORE BE IT RESOLVED: That we extend to Mr. Williamson and to the other officials and employees of the P. & O. Steamship Co., the hearty thanks of the members, their wives and their guests for the many courtesies extended us on this delightful trip.

COMMITTEE ON BOAT TRIP,
J. KNOX SIMPSON, M.D., Chairman."

Motion to adopt the above resolution, seconded, voted and unanimously carried.

So ordered.

Motion by Dr. Barge that the Association give Dr. Simpson a rising vote of thanks for his efforts in putting across this boat trip.

Motion seconded, voted and carried.

Rising vote of thanks to Dr. Simpson.

Motion by Dr. Holden that the Association give the Dade County Medical Society a rising vote of thanks for their many courtesies incident to this convention.

Motion seconded, voted and carried.

Rising vote of thanks to Dade County Medical Society.

The following proposed amendment to the Constitution was read by Dr. H. A. Day of

Orlando, said amendment to be voted on at the next annual meeting:

Article XI of the Constitution relative to amendments, shall be amended to read as follows:

"Any article of the Constitution may be amended by two-thirds vote of the Delegates registered at that Annual Meeting and referred to the component county societies for ratification during the ensuing year; each society ratifying by majority vote of its members present at any regular meeting. It being necessary for three-fourths of the component societies to vote in favor of its ratification during the year."

Section 3, Article VII of the Constitution relative to election of officers, shall be amended to read as follows:

"The officers of this Association shall be elected by the House of Delegates at its last regular session of the Annual Meeting, and referred to the last General Session for confirmation; and any member shall be eligible to any office named in Section 1 of Article VII of the Constitution, but no person shall be elected to such an office who is not in attendance during that Annual Meeting (except the Secretary, Treasurer, and the Editor of the Journal) and who has not been a member of the Association for five years."

Dr. Spiers announced that the Orange County Medical Society would hold its fifth annual picnic and barbecue on August 29th, and all members of the Florida Medical Association were invited to attend.

Invitation unanimously accepted.

The next order of business being the election of officers for the ensuing year, President Bryans called for nominations for President-elect.

Dr. Edward Jelks of Jacksonville, nominated by Dr. Homer L. Pearson.

Nomination seconded by Dr. L. M. Anderson and endorsed by Dr. Spiers.

Motion by Dr. Spiers that the nominations be closed and the Secretary instructed to cast the unanimous ballot of this Association for Dr. Jelks.

Motion seconded, voted and unanimously carried. So ordered.

Drs. Holden and Pearson appointed to escort Dr. Jelks to the rostrum.

Dr. Jelks: "Mr. President and Fellow Practitioners: This wholehearted action of yours has stirred something up in me in different ways that is quite a good deal more uncertain than the morning we started on this trip. I really don't know what to say. I do say this: I feel that such action in such a manner makes it unusually obligatory upon the one who has been given this honor to exert himself really more than it is proper for one man to do.

"I pledge you that it will be my honest intent to do everything I can for this Association.

"Again I thank you from the bottom of my heart, and I will do my very best."

Dr. M. J. Flipse of Miami was nominated for First Vice-President by Dr. Spiers.

Nomination seconded by Dr. Anderson.

Motion by Dr. Anderson that the nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Flipse. Seconded. Voted and carried.

So ordered.

Dr. W. H. Spiers was nominated for Second Vice-President by Dr. Leigh F. Robinson. Seconded by Dr. Barge.

Motion by Dr. Barge that the nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Spiers. Voted and carried.

So ordered.

Dr. N. A. Baltzell of Marianna was nominated for third Vice-President by Dr. Barge. Seconded.

Motion by Dr. Anderson that the nominations be closed and the Secretary instructed to cast a unanimous ballot for Dr. Baltzell. Voted and carried.

So ordered.

Dr. Shaler Richardson of Jacksonville nominated by Dr. Anderson for Secretary-Treasurer of the Association and Editor of the Journal.

Seconded.

Motion by Dr. Spiers that the nominations be closed and that a unanimous ballot be cast for Dr. Richardson.

Voted and carried.

President Bryans: "Dr. Feaster, it is my pleasure and honor to turn the gavel over to you, and I wish you a most successful year."

Dr. Feaster: "I thank you. I am deeply appreciative of this honor. It is the greatest honor in the power of this Association to bestow. I promise you that I shall leave nothing undone to accomplish those things that one in this office should strive to accomplish.

"The precedent that has been set by Herbert

Bryans demands that every possible thought and effort be given to it, to carry on the work which he has started. I am sure that the things you have heard at this meeting have impressed you with the fact that we have some very grave problems facing us this year, particularly economic problems and the question of legislative action that has to be secured. You all know that it cannot be secured except by individual work and the collective cooperation of the members of this Association, so we expect the help of each and every member of the Association this year in protecting ourselves.

"I shall always welcome criticism. If I am doing the wrong thing I always want to be told. If something ought to be done, I want to know it. And I will appreciate your criticism."

President Feaster called on Dr. L. M. Anderson to present the Past-President's button to Dr. Bryans.

Dr. Anderson: "Herbert, this pleasure that has devolved upon me is one of the great pleasures that sometimes come to us. When I pin this Past-President's button on you it is with high esteem and gratitude for your year's work. Your duties have been great and we hope, sir, when this button is pinned on you that you will not cease being useful in the Association.

"This has been a pleasure to me. It relegates you into my class. You can sit back and talk to any of us country fellows now. When President you could not do that.

"I hope, sir, that you will wear this button with all the honor and dignity of a President of this Association. And I want to congratulate you on your year's work."

Dr. Bryans: "I thank you."

President Feaster announced that he would be unable to name all of the committee appointments at this time, because of the changes made by the amendments of the By-Laws.

It was suggested by Dr. Spiers that the new committee members be named at a later date. The Orange County picnic and barbecue will be held in August, and Dr. Spiers requested committees to meet at the time of this picnic.

There being no further business to come before the meeting, on motion, duly seconded and carried, the meeting adjourned, *sine die*.

REGISTRATION

The total registration during the Sixty-third Annual Meeting of the Florida Medical Association, held on board ship April 27, 28, and 29, was 309; members, 162; visitors, 29; exhibitors, 9; Woman's Auxiliary, 109.

REGISTRATION

Officers

Bryans, Herbert L., President.....Pensacola
Feaster, Orion Otis, President-elect.....St. Petersburg
Turberville, John S., Third Vice-President....Century
Richardson, Shaler, Secretary-Treasurer..Jacksonville
Thompson, Stewart, Business Manager....Jacksonville

Alachua County Medical Society

Andrews, Edwin H. .....Gainesville
Maines, John E., Jr. .....Gainesville
Mathers, Fred .....Gainesville
Summerlin, J. L. .....Gainesville
Thomas, William C. .....Gainesville

Bay County Medical Society

Roberts, William C. .....Panama City

Brevard County Medical Society

Kenaston, T. C. .....Cocoa

Broward County Medical Society

Connor, A. B. .....Ft. Lauderdale
Hendricks, Elliott M. .....Ft. Lauderdale
McClellan, Geo. S. .....Pompano
Peavy, Henry J. .....Ft. Lauderdale
Robinson, Leigh Fowler .....Ft. Lauderdale

Columbia County Medical Society

Anderson, L. M. .....Lake City
Nichols, William S. .....Lake City

Dade County Medical Society

Agos, Isadore Henry .....Miami
Alexander, Julius .....Miami
Aronovitz, Samuel .....Miami
Barge, Hubert A. .....Miami
Bible, C. J. .....Miami
Burch, R. N. .....Miami
Cooke, H. Hamilton .....Miami
Day, George H. .....Miami
Dunaway, Carl E. .....Miami
Flipse, M. Jay .....Miami
Gowdy, Francis A. .....Ft. Pierce
Haggard, Wm. Andrew .....Miami
Hall, John E. .....Miami
Harris, David Watson .....Miami
Holmes, Roy J. .....Miami
Howell, R. Spencer .....Miami
Jones, Walter Colquitt, Jr. .....Miami
Lamar, C. P. .....Miami
Lewis, Taylor .....Miami
Light, S. D. W. .....Miami
Lucinian, Joseph H. .....Miami
MacDonell, Geo. Nowlan .....Miami
McKenzie, Jack A. .....Miami
McKibben, Wm. Watson .....Miami
Manson, Plumer Jacobs .....Miami
Marsh, Lucille J. .....Miami
Medlin, Willard Buford .....Miami
Mosley, R. Sam .....Miami
Payton, Frazier J. .....Miami Beach
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OUR PRESIDENT

Dr. Orion Otis Feaster, a native son of Florida, was born in Micanopy, Alachua County, April, 1893.

After graduating from the Micanopy High School, Doctor Feaster entered Southern College from which he received an A. B. degree in 1912. He continued his studies at the Jefferson Medical College, graduating from the medical department in 1916. During 1916 and 1917, Doctor Feaster was an interne at the South Side Hospital, Pittsburgh.

In 1917, Doctor Feaster enlisted in the army where he served for a period of two years. On being discharged, he returned to Florida and opened offices at St. Petersburg where he has practiced continuously up to the present time. He limits his work to radiology.

Doctor Feaster's natural gift of leadership has placed him in the foreground in both civic and professional circles. Besides his work on the staffs of the St. Anthony and St. Petersburg City Hospitals, he served his society for thirteen years in the capacity of Secretary and one year as President. The Florida Medical Association availed itself of his time and talent on its Executive, Scientific and Medical Economics Committees before bestowing upon him the office of President. He is a member of the Pinellas County Medical Society, the Florida Medical Association, the Southern Medical Association, American Medical Association, American Radium Society, Diplomate in Radiology, and a member of the American Board of Radiology.

Dr. Feaster and Miss Juanita Pipkin of Mulberry were married on May 26, 1917. They have three sons: Orion Otis, Jr., John Pipkin and William Laney.

THE CONVENTION CRUISE

The Sixty-third Annual Meeting of the Florida Medical Association was held aboard the Steamship "Florida". The meeting was a decided success. The P. & O. Steamship Company were wonderful hosts and overlooked no opportunity to further the convenience and pleasure of those aboard.

Although all of the meetings were held as scheduled, there was still time for entertainment. About sixty-five miles from Miami the SS. "Florida" was anchored in quiet waters and a small boat lowered for those who wished to fish. Treasure hunts, dancing and splendid meals in the dining room added to the enjoyment of those present.

The boat left Miami Monday morning and arrived at Havana Tuesday noon. Tuesday afternoon sightseeing cars were at the dock and took the crowd to many interesting places in Havana. Until midnight Tuesday the time was devoted to pleasure and entertainment. The return trip ended Wednesday noon at Miami. An official of the P. & O. Steamship Company made the statement that this was the most orderly group which had cruised on their ship in many years.

The registration totalled 309. Of this number, 162 were members of the Association, 38 visitors and 109 members of the Woman's Auxiliary and their guests. Eight exhibit spaces were occupied and the representatives of the various exhibiting firms filled an important part in making this meeting a success.

Complete proceedings of the meeting, as well as the names of new officers, appear in this Journal.

CHANGES IN BY-LAWS

In the proceedings of the Sixty-third Annual convention which appear near the front of this Journal will be found the actions of the House of Delegates making a number of changes in the By-Laws.

Representation from each of the six districts is required on practically all committees, the

set-up to be the same as that in vogue for the Executive Committee and the Committee on Scientific Work.

The Councilor Districts were reduced from twenty-one to twelve. Under the present arrangement, two councilors will be appointed in each of the six large districts set up for committee representation. In other words, each of the large districts will be divided into two councilor districts, making twelve councilor districts in all. The counties comprising these two classes of districts will be found in the proceedings as published in this Journal.

Another change in the By-Laws was the increasing of State dues from $7.50 to $10.00 per annum, the additional amount of $2.50 from each member to be set up in the Association's books as an emergency fund. The discussions brought out the point that there is a real need for funds in connection with medical legislation.

Another change in the By-Laws was a resolution enlarging the Section on medical ethics. This resolution is also reproduced in full in the proceedings published in this Journal.

With a few exceptions, new committee appointments were made by the President in time to be included in this month's issue of the Journal. The appointments as shown in the schedule of committees indicate a great deal of time and thought on the part of our President. Had it not been for the change in the By-Laws pertaining to the set-up of committees, the list published could have been entirely complete. However, owing to this change, the appointments as previously prepared had to be altered and supplemented in order to conform to the action of the House of Delegates. The committee list will be completed during the month and published in next month's Journal.

The By-Laws, as amended, require the committees to meet immediately after the annual convention and elect their chairmen. It was not possible to complete the list of appointments in time for this procedure. President Feaster has therefore designated chairmen for the committees which were not complete in time for them to hold their meetings. He has suggested that this editorial mention the fact that he has taken the liberty of naming the chairmen subject to confirmation or change by the committees at their first meetings.

MATERNAL AND CHILD WELFARE INSTITUTE TO BE HELD FOR MEMBERS OF FLORIDA MEDICAL ASSOCIATION

In line with other efforts being made to reduce the maternal and infant death rate by physicians and health officials, the Florida Medical Association announces a series of postgraduate institutes on maternal and child care to be held during the first two weeks in June.

The tentative schedule of institutes includes West Palm Beach, Miami, Fort Myers, Tampa, Lakeland, Orlando, and Daytona. Plans are being made to extend the series to other sections of Florida after July 1st.

The courses are to be conducted in cooperation with local medical societies. Each institute will last two days and will consist of afternoon and evening sessions.

The lecturers are to be recognized teachers of pediatrics and obstetrics chosen by a special committee representing the Florida Medical Association. Tentative plans have been made to bring Dr. Horton Casparis, head of the Department of Pediatrics, Vanderbilt University, to Florida to conduct part of these courses. Dr. Casparis is widely known as one of the leading authorities and lecturers on pediatrics in the country. The obstetrician who is to conduct the obstetrical section of the series has not been chosen, but several well-known teachers are being considered.

The courses are to consist of lectures and clinical demonstrations, illustrated by stereopticon slides and motion pictures. The local medical societies will be asked to furnish clinical material.

Special emphasis will be placed on prenatal, delivery, and postnatal care. Growth and development, infant feeding, and health habits are to be stressed by the pediatrician. Discussion also will be centered around the diseases common to infancy and childhood, including diagnosis and treatment.

Funds making possible this series of institutes have been secured by Dr. W. A. McPhaul, State Health Officer, from the Children's Bureau of the United States Department of Labor. The State Board of Health acts as agent for the use of this money, which is earmarked in the budget for the new bureau of Maternal and Child Health, and which is set aside for the program of Professional Education.

SUBJECTS TO BE TREATED BY SHORT COURSE SPEAKERS

The topics selected by the physicians who will give the Short Course for Doctors of Medicine the week of June 22-27 at the University of Florida, Gainesville, are as follows:

PEDIATRICS—Dr. Wilburt C. Davison—Monday, Tuesday, and Wednesday:
- Infant Feeding
- Summer Diarrhea
- Contagious Diseases (Treatment)
- Syphilis
- Rheumatic Fever

NEUROPSYCHIATRY—Captain Walter S. Jensen, M. C.—Monday, Tuesday, Wednesday, and Thursday:
- Psychiatry in Medicine
- The Minor Psychoses
- The Epilepsies and Epileptic Psychoses
- The Traumatic Psychoses
- Schizophrenia
- Child Psychiatry

MEDICINE—Dr. O. W. Bethea—Monday, Tuesday, and Wednesday:
- Amebiasis
- Arthritis
- Thyroid Disease
- Use and Abuse of Purgatives
- Vitamin Deficiency Diseases
- Heart Pain

OBSTETRICS—Dr. Otto H. Schwarz—Wednesday, Thursday, Friday, and Saturday:
- Eclampsia, Pathology and Treatment
- Puerperal Infection, Etiology, Prophylaxis, and Treatment
- Cesarian Section
- Breech Presentations
- Contracted Pelves
- Antepartum and Postpartum Hemorrhage

GYNECOLOGY—Dr. Emil Novak—Thursday, Friday, and Saturday:
- Recent Developments in Gynecological Endocrinology and Organotherapy
- Causes and Treatment of (1) Amenorrhea (2) Dysmenorrhea
- Sterility, Causes and Treatment
- Functional Uterine Bleeding
- Precancerous Conditions in Cervix and Body of Uterus

SURGERY—Dr. Charles Reid Edwards—Thursday, Friday, and Saturday:
- Infections and Tumors of the Mouth
- Infections and Tumors of the Breast

SCHEDULE OF FOURTH ANNUAL SHORT COURSE FOR DOCTORS OF MEDICINE IN FLORIDA
June 22 through 27, 1936, at Gainesville, Florida

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
9:00—10:00	Pediatrics Davison	Pediatrics Davison	Pediatrics Davison	Gynecology Novak	Gynecology Novak	Gynecology Novak
10:00—11:00	Neuro-psychiatry Jensen	Neuro-psychiatry Jensen	Obstetrics Schwarz	Surgery Edwards	Surgery Edwards	Surgery Edwards
11:00—11:30	Recess	Recess	Recess	Recess	Recess	11:00—12:00 Obstetrics Schwarz
11:30—12:30	Medicine Bethea	Medicine Bethea	Medicine Bethea	Obstetrics Schwarz	Obstetrics Schwarz	12:00—1:00 Surgery Edwards
12:30—2:00	Luncheon	Luncheon	Luncheon	Luncheon	Luncheon	
2: 0—3:00	Neuro-psychiatry Jensen	Neuro-psychiatry Jensen	Neuro-psychiatry Jensen	Surgery Edwards	Surgery Edwards	
3:00—3:15	Recess	Recess	Recess	Recess	Recess	
3:15—4:15	Medicine Bethea	Medicine Bethea	Medicine Bethea	Gynecology Novak	Gynecology Novak	
4:15—4:30	Recess	Recess	Recess	Recess	Recess	
4:30—5:30	Pediatrics Davison	Pediatrics Davison	Obstetrics Schwarz	Neuro-psychiatry Jensen	Obstetrics Schwarz	
8:00	Symposium: "Upper Respiratory Diseases"	Roundtable discussion		Symposium: "Fractures"	Roundtable discussion	

Early Metastases from Mouth and Breast Malignancies
Gastric and Duodenal Ulcers
Gall-Bladder Disease
Genito-Urinary and Rectal Tumors

SYMPOSIUM ON RESPIRATORY DISEASES—Monday evening:
Dr. W. Atmar Smith
Dr. Herschel C. Crawford
Dr. M. Jay Flipse

SYMPOSIUM ON FRACTURES—Thursday evening:
Dr. H. Earle Conwell
Dr. Arthur H. Weiland
Dr. Frank L. Fort

FACULTY AND LECTURERS

Dr. Oscar Walter Bethea, Professor of Clinical Medicine, Tulane University, New Orleans, Louisiana.

Dr. Wilburt C. Davison, Professor of Pediatrics and Dean of Duke University School of Medicine, Durham, North Carolina.

Dr. Charles Reid Edwards, Professor of Clinical Surgery, University of Maryland School of Medicine, Baltimore, Maryland.

Captain Walter S. Jensen, Director of Department of Neuropsychiatry, School of Aviation Medicine, Randolph Field, Texas.

Dr. Emil Novak, Associate Professor of Obstetrics, University of Maryland, Baltimore, Maryland.

Dr. Otto Henry Schwarz, Professor of Obstetrics and Gynecology, Washington University School of Medicine, St. Louis, Missouri.

GENERAL INFORMATION

REGISTRATION

The Committee on the Post Graduate Course will collect a registration fee of $5. This is the only necessary expense in connection with the course except transportation to and from Gainesville, lodging and meals.

Registration cards will be mailed to doctors in the state. Doctors who expect to attend the course are requested to register in advance in order that adequate accommodations may be arranged.

INFORMATION AND REGISTRATION DESK

The information and registration desk will be located in Room 107, Peabody Hall. Registration will be held from 8 to 9 o'clock, Monday morning, June 22. Location of lecture and exhibit rooms will be given at the information



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desk. Doctors who arrive in Gainesville Sunday afternoon or evening prior to the opening of the course, may secure information at the office of the University Infirmary.

LODGING AND MEALS

Lodging may be secured in rooming houses near the campus for $1. Gainesville hotel rates are $1 and up. Reservations may be made by addressing the General Extension Division, University of Florida, Gainesville. Doctors who wish to make reservations are requested to indicate accommodations desired.

Meals may be secured at the University Cafeteria at the following prices: breakfast, .25, lunch, .35, and supper, .30.

LABORATORY AND EXHIBITS

The Florida State Board of Health will set up a model laboratory and give instruction in laboratory technique. There will be exhibits by the Florida Radiological Association on Roentgenology and by the Florida Tuberculosis and Health Association on Tuberculosis. Specialists will be in charge of exhibits throughout the week. Three recess periods in each day's program have been set aside during which the doctors may visit the exhibits and enjoy recreation.

GOLF IN HAVANA

The Florida Medical Golf Association held its 1936 tournament on the beautiful links of the Havana Country Club. A large group of doctors participated in the play and they were unanimous in praising the sporty lay-out, conceded to be one of the finest in the world.

Scores were all rather high, no doubt due to the effects of the recent gulf stream crossing combined with a strong off-shore wind sweeping the course.

Mr. Juan Sabates, president of the Cuban Tourist Commission and past-president of the Havana Country Club, made all the local arrangements for the tournament and, incidentally, proved to be by far the best golfer in the group.

Prizes for the tournament were won by the following doctors:

First prize: Orlando Cup (low net score)—Dr. Shaler Richardson, Jacksonville.

Second prize: Runner-up (2nd low net score) gentleman's Monte Cristo Panama hat, donated by Mr. P. J. Saunders, president of the P. & O. Steamship Company — Dr. Joseph Taylor, Tampa.

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CANNED FOODS AND THE PUBLIC HEALTH

IV. BOTULISM

• Several of our readers have inquired as to the possibility of botulism resulting from the consumption of commercially canned foods. The canning industry is proud of the part it has played in the eradication from its products of this deadly type of food intoxication. We are glad to devote this space to a discussion of this important topic.

During recent years, the daily press periodically carries reports relating how one or more members of a family, or of a group of persons, were stricken after a meal, usually with fatal results. Sometimes these accounts describe how an "anti-toxin" was rushed to the scene—an indication that botulism was involved. These press reports often include the statement that a "canned food" was incriminated as the cause of the illness.

We wish to emphasize that as far as the records go, these outbreaks without exception are not attributed to foods commercially canned in this country. In practically every instance, it was found that the foods —usually of a non-acid or semi-acid nature —had been preserved at home by the use of inadequate heat sterilization processes (1). These press reports, by not stating correctly the type of food involved, have done much to cast unwarranted suspicion on commercially canned foods as possible causes of botulism.

Botulism, or acute toxemia due to clostridium botulinum, is by no means a new affliction. As early as 1802—ninety-five years before van Ermengem discovered the true cause of the intoxication—warnings were issued against botulism. However, not until severe outbreaks occurred in this country some fifteen years ago, was it realized that cognizance should be taken of the fact that foods canned by the methods used in those days could become contaminated with the toxin of this organism. This fact having been realized, the canning industry took immediate steps to prevent such contamination of their products.

Research was inaugurated and has been continued to which the industry has contributed not only financially, but also by the studies of scientists associated directly with the canning industry (2). The end result of these researches was the development of scientific methods of determination of heat sterilization treatments, or heat processes as they are known to the industry, which would be adequate to insure the safety of canned foods from the standpoint of botulism (3).

The effectiveness of the measures generally adopted by the canning industry of the United States is evidenced by the fact that no case of botulism attributable to an American commercially canned food has occurred during the past ten years (1a). Foods packed in commercial canneries are heat processed not only to insure protection from bacterial spoilage causing merely the loss of the food, but to render them safe from the standpoint of botulism, as well. In fact, a sterilizing process sufficient to insure the destruction of the most heat resistant strain of Cl. botulinum ever isolated is considered the minimum requirement of heat treatment of commercially canned foods. The National Canners Association has issued lists of scientifically determined processes for non-acid canned foods with which canners comply (4).

Such are the facts. The American canning industry offers its products to the consuming public for what they are; namely, wholesome and nutritious foods.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

1. a) *1935* Amer. J. Public Health, 25, 301 b) *1935* J. Amer. Diet. Assn. 11, 18

2. *1926* J. Bacteriology 31, No. 1 P. 71 *1923* Amer. J. Public Health, 13, 108 *1922* J. Inf. Dis. 31, 650

3. *1923* Natl. Res. Council Bulletin, 7, No. 37

4. *1931* N.C. A. Bulletin 26-L, Revised

This is the twelfth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

ACCEPTED AMERICAN MEDICAL ASSN. Committee on Foods

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Committee on Foods of the American Medical Association.

Third prize: (Low gross medal score), combination ophthalmoscope and otoscope, donated by the Southeastern Optical Company—Dr. A. H. Weiland, Coral Gables.

Fourth prize: (2nd low gross medal score), physician's leather bag, donated by Mr. Henry Parramore, president of the Surgical Supply Company—Dr. George Cook, Tampa.

Fifth prize: (Blind bogey), combination thermometer, barometer and humidity gauge, donated by the American Optical Company—Dr. Jack Peavy, Fort Lauderdale.

Dr. Warren Quillian of Coral Gables was elected president of the Golf Association for the ensuing year. Next year's tournament will be held in St. Petersburg.

STATE NEWS ITEMS

Dr. and Mrs. Daniel A. McKinnon of Marianna are making a two months' tour of Europe. Doctor McKinnon expects to visit a number of clinics while overseas and will also be a member of the party making a medical tour.

* * *

Dr. Osmah E. Harrell and Miss Margaret Jane Hughes, both of Jacksonville, were married in that city on April 6, 1936.

* * *

Dr. and Mrs. N. M. Weems of Boynton announce the birth of a son, William Fain Weems, at West Palm Beach on April 2nd.

* * *

Dr. C. A. O'Quinn of Perry is taking a course in public health work at Chapel Hill, N. C. He will return about July 1st to take charge of the Taylor County Health Unit.

* * *

Drs. E. C. Swift and Ferdinand Richards of Jacksonville announce the removal of their offices to 614-616 Greenleaf Building.

* * *

Dr. William H. Pickett was recently made Director of the Escambia County Health Unit. Doctor Pickett obtained a year's leave of absence as county health commissioner of Saginaw County, Michigan, to return to his native State of Florida. He is a member of the Escambia County Medical Society as well as the Florida Medical Association.

* * *

Dr. Julius C. Davis of Quincy was recently appointed a member of the State Board of Medical Examiners by Governor Sholtz.

THE HOME MILK PRODUCERS ASSOCIATION

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The Home Milk Producers Association is owned solely by local dairy farmers—it is organized under the cooperative laws of the State of Florida and represents the only dairy cooperative within the state today.

Only university recommended feeding formulae are used by Association dairymen.

The Association affords the most complete dairy control laboratory south of the Mason-Dixon Line.

"Home Milk" is a local product—not one gallon is imported.

Only local labor is employed.

All employes of farm and plant undergo medical examinations twice yearly.

All herds are tested for tuberculosis.

Only Florida products are used when obtainable—Our milk bottles are made in Florida.

The Association operates the only Evaporated Milk Plant south of Baltimore, Maryland.

"Cellophane" Protective Hoods are an exclusive feature of "Home Milk."

We deliver from Pompano on the north to Key West on the south.

A. W. Ziebold, former Chief Dairy Inspector and later Director of Public Welfare for the City of Miami, is employed as general manager of the Association.

We offer deliveries to the home or through stores of Milk—Certified, Pasteurized, Raw—Buttermilk, Chocolate Milk, Cream, Cottage Cheese, and Butter.

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Dr. David R. Murphey of Tampa presented a paper on "The Treatment of Carcinoma of the Cervix by the Combined Use of Relatively Small Amounts of Radium and Deep X-ray" at the Kansas City session of the American Medical Association this month.

* * *

Dr. and Mrs. James H. Putnam of Miami announce the birth of a daughter, Barbra Sue, on March 18th.

* * *

Dr. Joseph N. Fogarty of Daytona Beach died May 5 at the Post Graduate Hospital, New York. Doctor Fogarty was well known in Florida, having served as mayor of Key West and also as mayor of St. Augustine.

* * *

The annual meeting of the American Association for the Study of Goiter will be held in Chicago June 8, 9, and 10.

DR. HARRY DASH JOHNSON

Dr. Harry Dash Johnson died in Daytona Beach February 27, 1936. Dr. Johnson was born in New Jersey, in 1877, the son of a physician. He was graduated from Bellevue Medical College in 1897. After serving 18 months at New York City Hospital on Blackwell's Island, he took post-graduate work in physical diagnosis under Dr. Alexander Smith again at Bellevue. Later he became assistant and house surgeon at New York Maternity Hospital, New York City. He then entered general practice in New York City, where he continued for thirty-three years until coming to Daytona Beach in 1929 on account of ill health.

He was affiliated with the N. Y. State Medication Association, N. Y. Co. Association, N. Y. University Alumni, New Hampshire Medical Association, New Jersey Medical Association, American Medical Association, Southern Medical Association, Florida Medical Association, Volusia County Medical Society. He served on the staff of the Halifax District Hospital, and was a founder of St. Johns Guild, N. Y. C. Dr. Johnson was an Elk, Mason, and member of the Episcopal Church.

Dr. Johnson is survived by his widow, four children, and a brother-in-law, Francis E. Knowles, Miami, Florida.



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GEORGE E. W. HARDY

Dr. George E. W. Hardy, prominent Tampa surgeon, died suddenly of a heart attack March 26, 1936, after a short illness.

Dr. Hardy was born in Baltimore, Maryland, in 1892. He received his education in that city and held the degree of Bachelor of Arts and Doctor of Medicine from Johns Hopkins University.

He came to Tampa and established practice in 1922. He has served on the staffs of the Gordon Keller Hospital and the Tampa Municipal Hospital. He held the rank of major in the Florida National Guard and was assigned as surgeon to the 116th Field Artillery. He was also surgeon for the Atlantic Coast Line Railway in Tampa.

Dr. Hardy was a member of the Hillsboro Lodge of Masons, the Rotary Club, the County and State Medical Societies, the A. M. A. and the American College of Surgeons.

COMPONENT COUNTY SOCIETIES

ALACHUA COUNTY MEDICAL SOCIETY

Following are the officers elected by the Alachua County Medical Society to serve for 1936:

President—Edwin H. Andrews, Gainesville.
Vice-President—R. E. Summit, Gainesville.
Sec'y-Treasurer—H. M. Merchant, Gainesville.

BROWARD COUNTY MEDICAL SOCIETY

BROWARD COUNTY MEDICAL SOCIETY IS 100% PAID FOR 1936. CREDIT FOR THIS ACHIEVEMENT CAN LARGELY BE GIVEN TO THE FOLLOWING OFFICERS:

President—E. M. HENDRICKS, FT. LAUDERDALE.
Vice-President—R. H. STOVALL, FT. LAUDERDALE.
Sec'y-Treasurer—ROBERT E. BLOUNT, FT. LAUDERDALE.

DUVAL COUNTY MEDICAL SOCIETY

A regular meeting of the Duval County Medical Society was held April 7 in the Mayflower Hotel, Jacksonville. Dr. J. Arnold Bargen of the Mayo Clinic, Rochester, Minn., was the guest speaker, choosing as his subject, "Medical Treatment of Dysenteries."

SOUND ADVICE

MILLIONS smoke cigarettes apparently without harm. In a small minority of cases, smokers with sensitive throats are affected by the irritant properties of smoke. Physician's advice to stop smoking, at least temporarily, is too often not obeyed. The next best advice is, try Philip Morris—the only cigarette *proved* less irritating.★

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★ *Laryngoscope 1935 XLV, 149-154*
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241-245
N. Y. State Jour. Med. 1935, 35—No. 11,590

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MENTAL patients have every comfort that their home affords.

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At the May meeting of the Duval County Medical Society, held May 5, Dr. Kenneth A. Morris presented a paper on "Surgery in the Treatment of Pulmonary Tuberculosis." A moving picture on the same subject was presented as part of the program. Discussions were led by Dr. Louie Limbaugh and Dr. W. McL. Shaw.

LAKE COUNTY MEDICAL SOCIETY

THE LAKE COUNTY MEDICAL SOCIETY HAS BEEN PLACED ON THE HONOR ROLL. 100% OF SOCIETY DUES HAVE BEEN PAID FOR 1936.

At the regular meeting of the Lake County Medical Society, held April 3, Dr. Spencer A. Folsom of Orlando was guest speaker. Doctor Folsom presented a paper on "Hyper Insulin" which was very well received by the Society.

PINELLAS COUNTY MEDICAL SOCIETY

A meeting of the Pinellas County Medical Society was held at the St. Petersburg Shrine Club at 6:30, May 1st. After dinner a scientific session was held, the program consisting of a paper by Dr. G. E. Miller on "Influenza." This meeting was in spirit a homecoming celebration for Dr. O. O. Feaster, the new president of the Florida Medical Association.

POLK COUNTY MEDICAL SOCIETY

The Polk County Medical Society is this year headed by the following officers:
President—S. A. Clark, Lakeland.
Vice-President—W. W. Shafer, Haines City.
Sec'y-Treasurer—J. R. Boulware, Jr., Lakeland.

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Many social activities, sponsored by the Peninsular & Occidental Steamship Company. were enjoyed by the members of the Woman's Auxiliary and their guests during the Convention cruise.

Monday afternoon the boat was anchored for several hours and during this time an opportunity for deep-sea fishing was given all those who wished to participate. Also, at this time a card party was given for the women. After several progressions of bridge, refreshments were served and beautiful prizes were presented to those holding high, second and low scores.

In the evening a treasure hunt created much enthusiasm, lasting about two hours before all the twenty-seven treasures were found.

Following the hunt, dancing in the Veranda Ballroom, and a floor show, consisting of Cuban Dances were enjoyed.

Touring cars met the boat in Havana and a most interesting sightseeing trip was given to all those attending the Convention. A few hours were left for shopping or more sightseeing, as desired.

It was a well-planned and enjoyable trip.

Blanche Mitchell,
(Mrs. John H. Mitchell)

* * *

Alachua County Auxiliary

Mrs. E. W. Veal of Jacksonville, president of the Auxiliary to the Florida State Medical Association, and Mrs. S. M. Copeland, also of Jacksonville, state publicity and press chairman, were guests of honor at a luncheon given by the Auxiliary to the Alachua County Medical Society, at Hotel Thomas, on the occasion of their visit to Gainesville.

Pastel shade flowers decorated the luncheon table and bouquets were presented the honorees, together with Mrs. George C. Tillman, immediate past president, and Mrs. Edwin H. Andrews, president of the local auxiliary.

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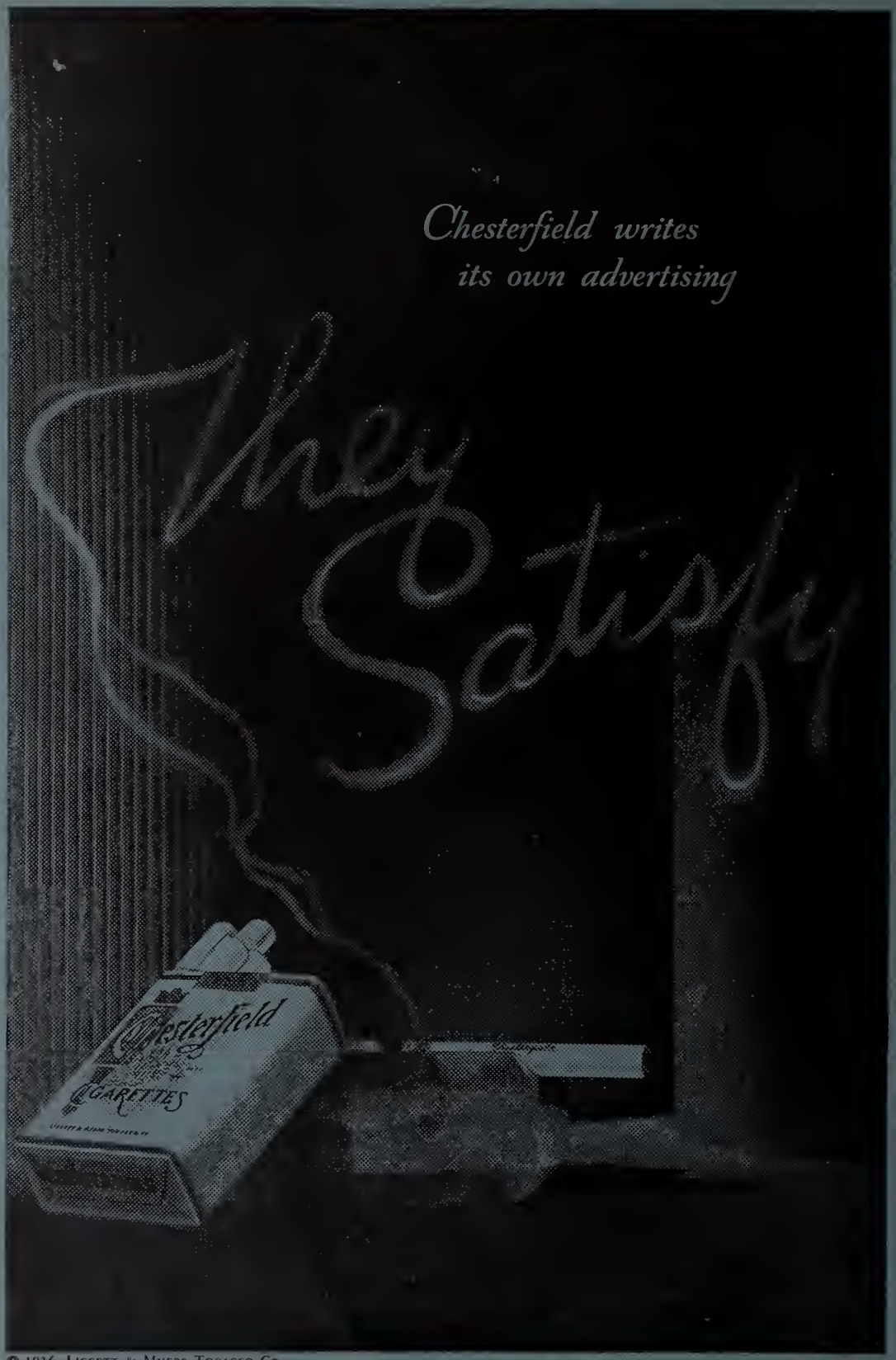
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SCHEDULE OF MEETINGS—COMPONENT SOCIETIES FLORIDA MEDICAL ASSOCIATION

COUNTY SOCIETY	PRESIDENT	SECRETARY	MEETINGS		Paid Members	
			Date	Place	No.	Per Cent
Alachua	J. E. Maines, Jr., M.D., 331½ W. University Ave., Gainesville	H. M. Merchaot, M.D. 124 E. University Ave., Gainesville	2nd Friday 7:30 P.M.	Primrose Grill Gainesville	22	85%
Bay	W. C. Roberts, M.D., Panama City	Allen H. Miller, M.D., Millville			8	62%
Brevard	I. F. Bean, M.D., Melbourne	Boh Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies	3	30%
Broward	Elliott M. Hendricks, M.D., 314 Sweet Building, Fort Lauderdale	R. E. Blount, M.D., 360 S. E. 26th Ave., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale	24	100%
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	9	90%
Dade	John E. Hall, M.D., Box 2722, Miami	M. E. Threlkeld, M.D., Congress Bldg.. Miami	1st Friday 8:30 P.M.	Club Rooms Huntiogton Bldg., Miami	191	86%
DeSoto-Hardee-Highlands	C. H. Kirkpatrick, M.D., P.O. Box 454 Arcadia	L. W. Martin, M.D., Sebring	2nd Tuesday 8:00 P.M.	Varies	6	60%
Duval	W. M. Shaw, M.D., St. James Bldg., Jacksonville	H. W. Porter, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	119	90%
Escambia	A. M. Ames, M.D. Blount Bldg. Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola	22	85%
Hillsborough	William C. Blake, M.D., 412 Citizens Bank Bldg. Tampa	James S. Grahle, M.D., 822 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa	101	91%
Jackson	C. D. Wbitaker, M.D., Dekle Bldg. Marianna	Lewis Pierce, M.D., Marianna	2nd Tuesday 7:30 P.M.	Hotel Chipola, Marianna	8	62%
Lake	R. H. Williams, M.D., Eustis	W. L. Ashton, M.D., Umatilla	1st Thursday 12:30 PM..	Eustis	13	100%
Lee	William H. Grace, M.D., 15 Earnbardt Bldg., Fort Myers	H. Quillian Jones, M.D. 18-20 Leon Bldg., Fort Myers	3rd Friday 7:30 P.M.	Lee Memorial Hospital Fort Myers	10	100%
Leon-Gadsden-Liberty-Wakulla-Jefferson	R. F. Godard, M.D., Key Building, Quincy	B. A. Wilkinson, M.D., Telepbone Bldg., Tallahassee	Quarterly 3:00 P.M.	Varies	20	97%
Madison	E. Long, M.D., Madison	Geo. O. Davis, M.D., Madison			3	100%
Manatee	S. G. Holliogsworth, M. D. 451 12tb, St, Bradenton	M. M. Harrison, M. D. Bradenton	3rd Tuesday 7:00 P. M.	Whitfield Country Club Bradenton	11	85%
Marion	J. N. Moore, M.D., 210-12 Professional Ocala	R. C. Cumming, M.D., Commercial Bank Bldg., Ocala	3rd Thursday 12:30 P.M.	Marion Hotel Ocala	22	100%
Monroe	Harry C. Galey, M.D., 532 Fleming St., Key West	W. R. Warren, M.D., 511 Eaton St. Key West	1st Sunday 9:00 P.M.	Varies	4	100%
Orange	William E. Sinclair, M. D. Clinic Bldg. Orlando	J. A. Pines, M.D., 106-10 E. Central Ave., Orlando	3rd Wednesday 8:30 P.M.	Varies	52	100%
Palm Beach	L. McK. Rozier, M.D., 411 Comeau Bldg., West Palm Beach	Lloyd J. Netto, M.D., 415 Comeau Bldg., West Palm Beach	4th Monday 8:00 P.M.	Good Samaritan Hospital West Palm Beach	50	91%
Pasco-Hernando-Citrus	R. D.Sistrunk, M.D., Dade City	John J. Bourke, M.D., Dade City	2nd Tbursday 7:00 P.M.	Varies	8	85%
Pinellas	F. E. Kauffman, M.D Coacbman Bldg., Clearwater	W. C. McConnell, M. D. 1005 Equitable Bldg. St. Petersburg	1st. and 3rd. Friday 6:30 P.M.	Shrine Club St. Petersburg	79	98%
Polk	R. L. Hughes, M.D., 225 E. Main St., Bartow	J. R. Boulware, Jr., M.D., P. O. Box 367, Lakeland	2nd Wednesday in Feb.. April, June, Aug., Oct., Dec. 1:00 P.M.	Lakeland	31	69%
Putnam	Allen P. Gurganeous, M. D. Palatka	A. E. Drexel, M.D., Palatka	2nd Tbursday 7:00 P.M.	James Hotel, Palatka	9	100%
St. Jobns	Herbert E. White, M.D., 401 First Natl. Bank Bldg St. Augustine	R. D. Harris, M.D., St. Augustine	3rd Tuesday 8:30 P.M.	Varies	9	90%
St. Lucie-Okeechobee-Indian River-Martin	J. D. Parker, M.D., P. O. Box 942, Stuart	E. B. Hardee, M.D., Vero Beach	3rd Thursday 8:00 P.M.	Varies	8	77%
Sarasota	C. B. Wilson, M.D., 1st B. & Tr. Bldg., Sarasota	J. E. Harris, M.D., 224 Commercial Ct., Sarasota	2nd Tuesday 8:30 P.M.	Varies	15	94%
Seminole	J. T. Denton, M.D., Meisch Bldg. Sanford	Douglass G. Scott, M. D. Box 489 Sanford	2nd Monday 7:00 P.M.	City Hospital Sanford	12	100%
Sumter	A. B. Albritton, M.D., Wildwood	W. E. Mitchell, M.D., Box 237 Coleman	2nd Tuesday	Varies	4	100%
Taylor	W. J. Baker, M.D., Foley	C. A. O'Quinn, M.D., Perry	Last Friday 8:00 P.M.	Dixie-Taylor Hotel, Perry	5	83%
Volusia	H. W. Henry, M.D., 205 State Bank Bldg., New Smyrna	W. C. Cbowning, M. D. 111 Palmetto St. New Smyrna	2nd Tuesday 7:30 P.M.	Varies	34	87%
Walton-Okaloosa	R. B. Spires, M.D., DeFuniak Springs	A. G. Williams, M.D., Lakewood	3rd Thursday 8:00 P.M.	Varies	6	100%

NOTE—Secretaries: Please submit information to complete the above schedule.



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OF THE
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American Medical Association, Atlantic City, 1937.
Southern Medical Association, Baltimore, Md., November 17-20, 1936.

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Today physicians know more about the ills of the heart and ways of the heart than ever before. They are better equipped than ever before to treat and control heart disease—and to guard against it as well.

Shortness of breath—fluttering of the heart—numbness of the extremities—these are among the symptoms that suggest an *immediate* trip to the doctor's. But even without warning symptoms, many a wise man sees his doctor at regular intervals—far less "servicing" than he gives his car, yet obviously, infinitely more important.

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CANNED FOODS AND THE PUBLIC HEALTH

V. FOOD IN THE OPEN CAN

• In September 1935, the facts about food in the open can were presented on this page. It was stated that there was no reason, from the standpoint of food poisoning, why food must be removed immediately after the can is opened. This statement bore the Seal of Acceptance of The Committee on Foods of the American Medical Association.

However, since that time, two incidents have occurred which lead us to present again the facts concerning food in the open can.

First, late last fall, a national organization dedicated to the relief of human distress during war and disaster, issued a list of precautions designed to reduce accidents in the home, in which it was erroneously recommended that food be removed from the can immediately. The Department of Agriculture detected this error and called it to the attention of those responsible for issuance of the recommendations. A correction was made as soon as possible but the damage had already been done. The original safety recommendations had meanwhile been issued in schools and newspapers throughout the country, thus giving further support to this old, unbased prejudice against canned foods.

Second, in the early months of 1936, a release regarding food in the open can was made by a national press service to newspapers throughout the land. The strong inference was made in this press release that food left in the open can might become hazardous to consumer health.

This dissemination of misinformation, referred to in the two instances cited above, has caused an increase in the number of consumer inquiries concerning the safety of food in the open can. To reply to these requests for reliable information, we can well quote from a recent release made by the Department of Agriculture (1).

(1) U.S.D.A. Press Release, Feb. 23, 1936

"It is just as safe to keep canned food in the can it comes in—if the can is cool and covered—as it is to empty the food into another container. Thousands of housewives are firm in the faith that canned goods ought to be emptied as soon as the can is opened, or at least before the remainder of the food goes into the refrigerator—one of the persistent food fallacies. The question keeps coming to the Bureau of Home Economics in letters from home-makers.

"A few acid foods may dissolve a little iron from the can, but this is not harmful, not dangerous to health. Cans and foods are sterilized in the 'processing'. But the dish into which the food might be emptied is far from sterile. In other words, it is likely to have on it bacteria that cause food to spoil.

"Whether in the original can or in another container, the principal precautions for keeping food are—Keep it cool and keep it covered."

AMERICAN CAN COMPANY

230 Park Avenue, New York City

This is the thirteenth in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.



The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Committee on Foods of the American Medical Association.



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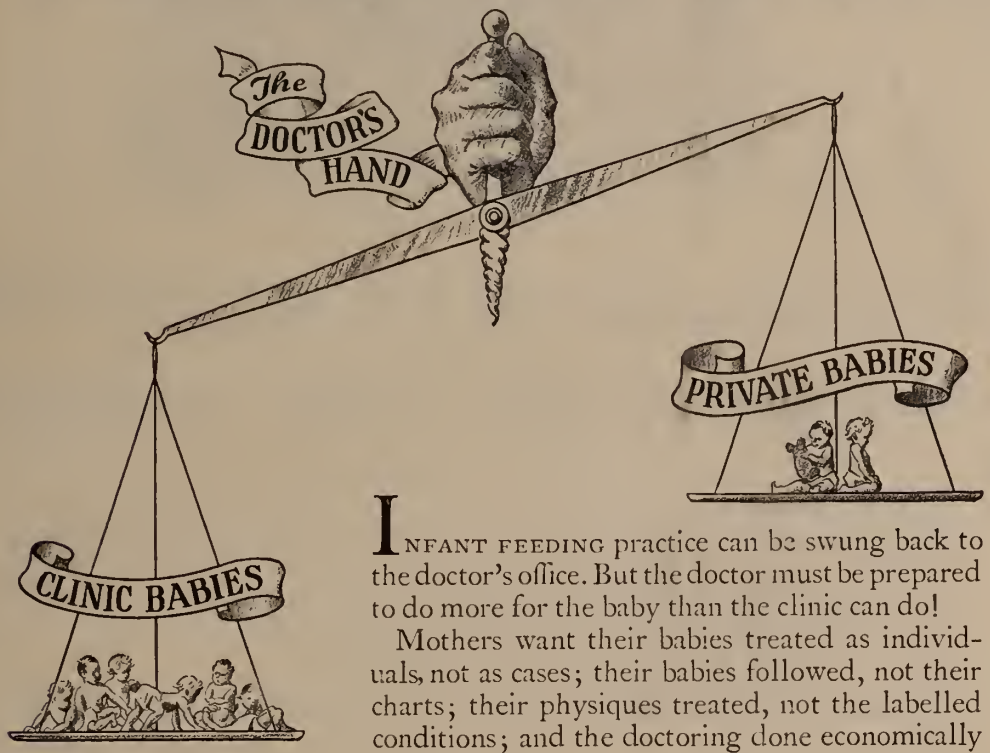
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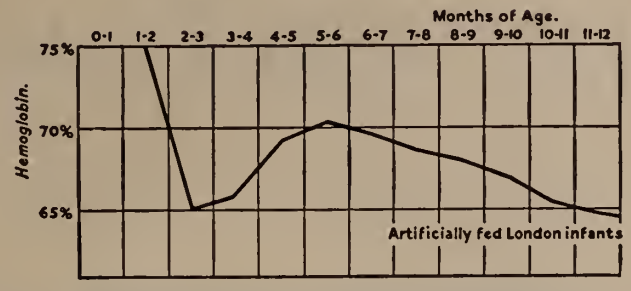
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Nutritional Anemia in Infants



Hemoglobin level in the blood of infants of various ages. Note fall in hemoglobin, which is closely parallel to that of diminishing iron reserve in liver of average infant. Chart adapted from Mackay. It is possible to increase significantly the iron intake of the bottle-fed from birth by feeding Dextri-Maltose With Vitamin B in the milk formula. After the third month Pablum offers substantial amounts of iron for both breast- and bottle-fed babies.

Reasons for Early Pablum Feedings

1. The iron stored in the infant's liver at birth is rapidly depleted during the first months of life. (Mackay,[1] Elvehjem.[2])

2. During this period the infant's diet contains very little iron—1.44 mg. per day from the average bottle formulae of 20 ounces, or possibly 1.7 mg. per day from 28 ounces of breast milk. (Holt.[3])

For these reasons, and also because of the low hemoglobin values so frequent among pregnant and nursing mothers (Coons,[4] Galloway[5]), the pediatric trend is constantly toward the addition of iron-containing foods at an earlier age, as early as the third or fourth month. (Blatt,[6] Glazier,[7] Lynch[8].)

The Choice of the Iron-Containing Food

1. Many foods reputed to be high in iron actually add very few milligrams to the diet because much of the iron is lost in cooking or because the amount fed is necessarily small or because the food has a high percentage of water. Strained spinach, for instance, contains only 1 to 1.4 mg. of iron per 100 gm. (Bridges.[9])

2. To be effective, food iron should be in soluble form. Some foods fairly high in total iron are low in soluble iron. (Summerfeldt.[10])

3. **Pablum is high both in total iron (30 mg. per 100 gm.) and soluble iron (7.8 mg. per 100 gm.) and can be fed in significant amounts without digestive upsets as early as the third month, before the initial store of iron in the liver is depleted. Pablum also forms an iron-valuable addition to the diet of pregnant and nursing mothers.**

Pablum (Mead's Cereal thoroughly cooked and dried) consists of wheatmeal, oatmeal, cornmeal, wheat embryo, brewers' yeast, alfalfa leaf, beef bone, iron salt and sodium chloride.

[1-10] Bibliography on request.

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PRESENT DAY CONCEPTIONS IN THE MANAGEMENT OF PROSTATIC OBSTRUCTION*

Louis M. Orr, II, M.D.,
and
Doran T. Rue, M.D.,
Orlando.

In bringing before you a discussion of the present day conceptions in the management of prostatic obstruction, it is intended that this be a consideration of the subject primarily for those engaged in general medical practice and not simply a urological dissertation for those among you who follow urology as a specialty.

In the present progressive era of rapidly changing ideas and opinions, it seems quite important that the medical practitioner, the family doctor, be kept in as close association with the current developments in the surgical aspects of the specialties as is possible. As time goes on he is going to be called upon more often by the patient to be of assistance in making decisions regarding various types of surgical intervention.

The varying opinions regarding present day management of the obstructing prostate gland illustrate the advisability of bringing before general medical assemblies a true cross section of a greatly discussed problem in surgery.

During the past few years the medical world has watched with great interest the development of transurethral resection as a method for the relief of prostatic obstruction. As is true with almost all surgical innovations, it was received throughout the country with much enthusiasm as a method of great promise. The high mortality rate of prostatectomy in years gone by assisted in making the newer procedure even more popular. The instrument manufacturers, with their usual alacrity and salesmanship, distributed their wares about the country in great quantities and even went along to the hospital with the instrument to instruct the surgeon in the method of removing the prostate gland transurethrally. This may sound a bit far-fetched, but it is nevertheless true, and did take place in many instances. These resectoscopes and cutting machines were sold to any and every one who had the price of the equipment, whether or not the physician was even a surgeon. Anyone who could use a cystoscope, whether skilled in its use of not, was encouraged to use a resectoscope.

The result of this initial wave of enthusiasm was obvious. The medical journals soon began to fill with articles indicating disappointment in the procedure, and extremely high mortality rates began to appear. Hemorrhage, both primary and secondary, with disastrous results, was reported as a complication to be feared. Dissatisfied patients with infected residual urine in their bladders and great urinary distress began to meet fellow patients with the same complaints. The resectionist himself began to become discouraged and soon condemned the operation and returned again to the open type of prostatectomy where he felt reasonably sure of himself and his patient.

With this wane in the enthusiasm regarding transurethral resection and the abandoning of the procedure by so many, ample time has now elapsed so that the profession is able to consider the results of the past few years. It was this change of front on the part of the urological profession that prompted the writer to attempt an analysis of the management of prostatic obstruction over the past few years.

In making this analysis, rather extensive questionnaires were sent out to over 200 members of the American Urological Association, both in this country and Canada. Care was taken that representative surgeons in every geographical area of the country received an equal opportunity to report on the work they had done and the opinions they had formed. Of this number 73 questionnaires were returned completely answered. A rather large number declined to answer.

It has been found that these 73 surgeons have performed 14,104 prostatic resections and 5,062 prostatectomies during the same period of time. These totals show that resections are almost three times greater in number than prostatecto-

*Read before the Sixty-third Annual Meeting of the Florida Medical Association, held on board the SS. "Florida", April 27, 28 and 29, 1936.

mies. There were also 214 operations on the bladder neck performed with the Young's punch, or similar punch instruments.

The total number of deaths from resections was reported to be 370, or 2.5%, and from prostatectomies 195, or 3.8%. Severe primary hemorrhages accompanying resection which necessitated opening the bladder numbered 107. Secondary hemorrhages requiring fulguration of the bleeding points 164, requiring transfusion 116, and hemorrhages requiring both measures 54. Six hundred and forty-eight severe infections were reported associated with resection, or 4.9% of all cases.

Forty surgeons reserve the procedure for small glands only. Thirty-two employ it in all types of hypertrophy. Four hundred and eighty-eight secondary resections were reported as necessary because of insufficient removal of tissue at the first operation. Not a single instance of regrowth of tissue was mentioned as a cause for the second resection. One hundred and five patients were reported who had troublesome incontinence, both temporary and permanent. Subsequent prostatectomies were performed on 172 patients previously resected and this figure would probably run considerably higher if all resected patients could be accurately followed.

In almost every instance the men performing the largest number of resections were having the best results and recommended the operation for practically all types of prostatic obstruction. Those performing fewer resections were more cautious in their choice of operation. The great majority recommended that the procedure be used in only the carefully selected cases and limited it to the smaller, atrophic glands, median bars and as a palliative relief in cases of malignancy. Only three men reported that they did not see any place in the surgical category for resection and two asserted the operation was based on unsound surgical principles, but in certain cases gave excellent results.

These results are convincing enough to show that transurethral prostatic resection is an operation of great usefulness and of tremendous value to the patient if in the hands of surgeons with sufficient experience and ability to make proper use of the instruments and equipment that have been placed at their disposal.

If the anatomy of the prostatic urethra is respected and the cutting confined to the hypertrophied gland, it is possible to remove the obstructing tissue and give the patient a good result and, as Bumpus recently added to this the remark, "provided that all the obstructing tissue is removed."

If the surgeon cannot fulfill the above requirements of the procedure his patient will not get a good result and dissatisfaction on the part of both is certain to follow. One urologist has only recently reported that 10% of all patients upon whom he has performed resections had had a primary resection elsewhere.

OPERATORS GROUPED AS TO NUMBER OF PROSTATIC RESECTIONS PERFORMED, SHOWING NUMBER OF PROSTATECTOMIES IN SAME PERIOD OF TIME.

	Total No. Operators	Total No. Resections	Mortality Rate	Opinions	No. Prostatectomies same operators	Mort. Rate
Above 500 Resections	5	4,757	1.9%	4 Stated almost ideal operations. 1 Great advance but over-rated.	526	5.1%
Between 400-500 Resections	2	800	3.3%	Use in every possible case	10	20%
Between 300-400 Resections	3	970	1.9%	2 Use in clear cut indications. 1 Uses in small glands only	627	5.2%
Between 200-300 Resections	7	1,689	2.3%	6 Use in practically all cases. 1 Small glands only	88	3.4%
Between 100-200 Resections	25	3,530	4.1%	13 Use in practically all cases. 12 Small glands, Bars	2,101	2.9%
Up to 100 Resections	31	1,358	3.6%	5 Use in 90% of all cases 26 Small glands and Bars.	1,710	4%

Prostatic resection is an operation which requires a great deal of patience and surgical skill and oftentimes considerable courage. No such operation should be attempted by one who is not a competent urological surgeon, able to meet and deal with any complication that might arise. He should be skilled in the use of the direct vision type of lens system and in the appreciation of the normal as well as the abnormal prostatic urethra. The operating team must be well trained and the operation carried out under the same precautions as any other major operation. Few operations in the urological category are as difficult to perform and carry through to a successful conclusion as is a transurethral resection. In no operation is competent nursing care so absolutely essential as after a resection. The catheter must be continually irrigated to prevent even the slightest obstruction from a small blood clot or a piece of mucus. Practically all secondary hemorrhages are caused by the patient's bladder becoming distended because of an obstructed catheter and once bleeding is started the clots filling the bladder produce a situation that may be one of grave emergency.

Patients undergoing prostatic resection are usually in the hospital for a much shorter period of time than those undergoing prostatectomy, hence a considerable economic saving. There is but little shock caused by the operation providing the anesthetic be a low spinal or a caudal injection. It is surprising that the very oldest of patients are able to be up and out of bed on the second or third day. The high frequency current has shown little or no effect on the patient except at the point of application of the cutting loop. Recent improvements in the cutting and coagulating currents of the generating machine cause only a minimum amount of local sloughing of tissue.

Infection is frequently mentioned as a disagreeable feature following resection. This may be due to either one of two causes, or both. First, there may be an insufficient amount of tissue removed resulting in an infected residual urine and, second, the prostate itself may have been grossly infected prior to the time of operation.* Still another cause, and quite often an important one, is a failure to pay attention to aseptic precautions in dealing with the catheter after operation. Secondary infection from this source may cause complications and lengthen convalescence for many weeks. Expert nursing care by trained urological nurses is here again of great importance and for the past three years the writers have demanded of every patient that these nurses be present day and night for at least 48 hours. Many anxious hours on the part of the surgeon can thus be eliminated.

Some of the complications of transurethral resection have been reported to be hemorrhage, both primary and late, cutting through the bladder wall into the peritoneal cavity or into the rectum, gangrene of the bladder, urethral stricture and interference with the external sphincter muscle causing incontinence. These complications are principally the results of incompetent operators and no doubt the same complications would occur if the same operators were just as incompetent in performing a prostatectomy.

The writers feel quite strongly that the unfavorable attitude taken by many urological surgeons toward prostatic resection is due largely to a lack of experience and a failure to attempt to overcome the technical difficulties by thorough study and conscientious application of the procedure. When one performs fifty resections it seems as though all the obstacles in various types of glands have been encountered. After performing a hundred and fifty, one readily realizes how little was known after the first fifty. Experience is the greatest teacher and this is one operation in surgery that the surgeon must learn for himself. He cannot have some one else demonstrate to him the interior of the prostatic urethra as it is being resected. Many mistakes will doubtless be made at first, but if there is a mistake let it be that of not having done *enough,* and *not* of having done too much. A secondary operation will *always* allow for the removal of more tissue, but a damaged sphincter muscle will always mean incontinence of urine and a very unhappy patient.

In our rather small series of over two hundred resections it has been found that accurate judgment in the amount of tissue necessary to be removed to give complete relief of obstruction is at times most difficult. Only recently a debilitated man of 70 years was resected and 20 grams of tissue removed from the lateral lobes. After 48 hours the catheter was removed and although the patient could urinate a residual urine of 16 ounces was present. A secondary resection resulted in removal of 15 additional grams of tissue, and still a large residual urine persisted. At a third resection 12 grams more were re-

moved, making a total of 47 grams. After this the patient obtained complete relief. All of these procedures occupied less than a month's hospital stay, and at no time did the patient exhibit the slightest reaction to his operative procedures. Fortunately in only 4 instances in the series have secondary resections been necessary.

The use of a cystometer to evaluate the muscular power of the bladder walls has been found to be of great assistance in giving a prognosis as to the amount of force the urinary stream will have following the resection. In any case of suspected atony of the walls, a cystogram of the bladder should be done as an unsuspected vesical diverticulum can lead to much embarrassment.

The objective in all types of prostatic surgery, no matter what operation is used, is to give as near a complete and permanent functional result as is possible with the minimum amount of discomfort to the patient. Care and study must be given each individual patient who presents himself with an enlarged prostate. Not all should be resected by any means. Some will be relieved, and oftentimes permanently so, by medical treatment only. Others with huge vascular glands, who are in good physical condition, should most certainly be advised to have a prostatectomy. The very large majority, however, can unquestionally be relieved by resection and this we have been able to do in more than 95% of all cases in our series. The operator who can remove 40 to 60 more grams of tissue with the resectoscope is naturally going to be able to get better results on the large glands than those unable to do so.

As to the permanence of the results of transurethral resection no one is yet able to definitely state. So little is known regarding the rate of growth of the hypertrophying prostatic tissue that time alone will furnish an answer. So far, however, the results as observed during the past 8 years have been quite permanent.

Caulk some years ago expressed the opinion that once the urethral obstruction in cases of prostatic hypertrophy was relieved, a vicious cycle had been broken and that with the abolishment of residual urine the rate of hypertrophy tends to diminish.

With this opinion, we most heartily agree.

DISCUSSION

Dr. J. C. Vinson, Tampa:

In their excellent paper, Drs. Orr and Rue have covered the field in a most intelligent manner. However, there are a few points about the removal of bladder neck constriction that should be accentuated. I can remember that some seventeen years ago I presented a paper before the Florida State Medical Association in which I advocated suprapubic drainage in all types of bladder neck obstruction. Since that time a good deal has been learned about different types of obstruction, and as a result, different procedures for overcoming the obstruction have been rightfully instituted. Removal of large hypertrophied prostates should be preceded by suprapubic drainage, for placing the bladder wall at rest offers the best opportunity for a return to normal function. Transurethral prostatectomy should be limited to those cases where the removal of a minimum amount of tissue would overcome the obstruction and restore the bladder to normal function.

Decision as to the method of approach and the type of operation should be left entirely to the good judgment of the urologist and that particular type of operative procedure instituted which will mean the conservation of the individual and the restoration of the bladder function.

Dr. John S. McEwan, Orlando:

I have had the pleasure of witnessing a great many of Dr. Orr's transurethral operations and he does very beautiful work.

In 1916 I read a paper before the Florida Medical Association on prostatic hypertrophy. At that time I was doing perineal and combined perineal and abdominal prostatectomies. Since then we have gradually worked into suprapubic prostatectomies.

In witnessing transurethral work and watching the outcome of these cases, I have come to the conclusion that every man using a cystoscope cannot do a transurethral prostatectomy and that is what many of them are trying to do. I think that it really takes an expert mechanic to do this transurethral work and do it well. Many of these men who are using the cystoscope think they are general surgeons but if you will notice the mortality rate in prostatectomies they try to do, you will agree with me that they should confine themselves to transurethral work. I think that men who are specializing in urology, should confine themselves to transurethral operations.

In cases of large hypertrophied prostates, I

agree with Dr. Vinson. With a distended bladder, there is no question in my mind, but that these patients should have a suprapubic prostatectomy with drainage. Small contracted infected bladders should be subjected to suprapubic prostatectomy, so that you can have sufficient drainage afterward. You take 40 or 50 grams of prostate from an infected bladder and what do you have—a great big raw surface that sometimes drains until the patient dies. The only way to handle these properly is by suprapubic prostatectomy. With a middle lobe or bar, these are ideal for transurethral resection.

I don't know so much about hemorrhages and other complications following this operation. I do know that I have done a great many suprapubic prostatectomies. I do know one thing about suprapubic prostatectomies, and that is that you can get perfect control of the bladder and perfect drainage. If you are careful, your postoperative hemorrhage will be very, very unusual.

I believe that transurethral prostatectomies are a great advance in surgery in selected cases with selected operators.

Dr. George H. Day, Miami:

I just want to endorse what the previous speakers have said about so-called urologists. I have had some thirty years in this sort of work, and the more I do urology the more I agree that the urologist of the future must be a man-sized surgeon. If I were to live thirty years longer I would be able to do a perineal prostatectomy as well as any of Young's pupils. However, I don't think that there is anything in urology that can be handled either by suprapubic or by perineal in 100% of the cases, and no man should attempt a prostatectomy without being a master of both operations.

Now as to resections. As I see it, other than bars, small median lobes and palliative treatment for inoperable malignancy, I believe that surgery offers better results than resections. Why? I think we are losing sight of the fact that the biggest thing to be kept in mind constantly in removing obstruction is the potential malignancy. You have seen, as I have, the results in some resections. I don't know of any man who claims a cure of malignant prostate with resection. Do you remember of having ever cured any man of a malignant prostate with resection? I believe that these things go in cycles. And I believe thoroughly that there is a definite swing-back to surgery. I believe in the main, that relief for obstruction is complete removal, particularly for a functional result in potential malignancy. Along that line is the recent report of the carcinoma registry of the American Urological Association. It is wonderful to have a prostatectomy followed by a complete functional result. Scar tissue is left in spite of all you can do on enucleation. We should follow our surgery with resection. I think that now we have the cart before the horse. I believe that the plan of the future will be along this line. Follow up your surgery with resection and your patient will be relieved.

I have very much enjoyed this splendid paper by Doctors Orr and Rue.

Dr. Doran T. Rue, Orlando (concluding):

I would like to add a few points regarding this paper. We have not attempted to analyze the indications for resections but have purposely confined our remarks to general considerations of prostatic resection.

As Doctor Vinson has mentioned—the importance of suprapubic drainage cannot be underestimated and no urethral catheter ever equals a suprapubic one when drainage is the pressing problem. However, we do feel that the large majority of cases can be adequately and satisfactorily handled without resorting to this added surgical procedure.

Dr. Day has brought up the problem of malignancy of the prostate and its relation to transurethral resection. I believe that when carcinoma of the prostate is suspected, one of the most important contraindications for resection exists. It most certainly is not wise to disturb these cells and cause thereby a rapid dissemination of the tumor. However, the use of transurethral resection as a palliative measure in carcinomatous prostate is an entirely different situation and its value cannot be questioned in those cases.

It is interesting to compare at autopsy the structural anatomy after enucleation of the prostate with that after transurethral resection. I have consistently been impressed with the marked irregularities of the prostatic pouch, the tortuosities of the urethral canal and the presence of overhanging tissue when enucleation has been done. In contrast to this, one finds a fairly sharply delineated channel after transurethal resection. In our experience at least, this has been a rather constant distinction and I believe all of us agree that the goal of prostatic surgery is the relief of the obstruction with as little interference

with the anatomy of the prostatic urethra as is possible.

In Dr. Orr's behalf, as well as my own, I would like to thank all of you who have so kindly entered into this discussion.

COORDINATION OF PRIVATE PRACTICE AND PREVENTIVE MEDICINE*

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A good deal of comment has appeared in medical publications during the last few years dealing with the physician and his relation to public health. First, as to health education. Much published material might convey the impression that the physician as a health educator is a novel phenomenon when, as a matter of fact, the medical activity of today, looking toward instruction of the public, is merely a reawakening and not an initial incursion into a new field.

The doctor has been a health educator ever since there were doctors, at least until the time when changes in medical practice consequent on a changed community life in America began to crowd the family doctor out of the picture in favor of the specialist. The family doctor felt it his duty to instruct his regular patients about such matters as smallpox vaccination and other necessary steps to preserve their health. It is true that he did not promote the conception of the periodic health examination as we know it today, but he did encourage his patients to keep in constant and friendly touch with him and to confide in him matters touching on their health. His relationship was informal but effective. Even in the face of official endorsement of the periodic health examination by a number of organizations, including the American Medical Association, there are many who hold that the less formal but more intimate relations between the old family doctor and his patients were more desirable and effective than are the practices that are advocated today.[1]

In the midst of great and sometimes perplexing changes in the nature of our community organization changes are taking place in medical practice. It is interesting to note that these changes are in the direction of returning to the physician some of the functions which he used to exercise in simpler times but which have been taken over by boards of health and voluntary organizations of one kind or another. The doctor is beginning to interest himself anew in problems of public health and health education. Those who have not troubled to acquire historical perspective are prone to consider that the doctor is making a new incursion into unfamiliar fields when as a matter of fact history shows very definitely that in many a state, city and county, public health work was initiated as a result of demands made by public spirited physicians, either individually or as groups.

The function of the physician as a health educator in his relations with his private patients need not be discussed extensively. He discharges his functions in that regard for the most part satisfactorily. It is true that there are physicians who hold that the less the patient knows the better off the patient will be. There are some patients concerning whom this is a fact beyond dispute. Some individuals seize on every bit of health information and convert it into material either for controversy with the doctor or for a state of neurasthenia. To such patients may well be applied the dictum of Oliver Wendell Holmes, who said: "The patient is no more entitled to all the doctor's knowledge than he is to all the medicine in his saddlebags." The patient is not able to assimilate all the doctor's knowledge; therefore, in his own interest he ought not to have it. On the other hand, there can be no question that the patient is entitled to sufficient information to enable him to cooperate intelligently with the doctor.

The public has awakened to a keen curiosity about its health. This curiosity is mainly misdirected, the interest often converging where it ought not to and failing to focus where it might accomplish good. There is no lack of interested persons busily engaged in misleading the public interest in health for private profit. I shall not go into any discussion of the subversive influences apparent today in magazines, on billboards, in newspapers and invading our homes by way of the radio. These are all too familiar. They constitute, in my judgment, the plainest handwriting that has ever been written admonishing the physician that he must function as a health educator if he is to save the public from the fruits of its own folly and if he is to retain or regain leadership among guardians of the health of the people.

*Read before the Seventh Annual Meeting of the Florida Public Health Association, Orlando, Dec. 2, 3, 4, 1935.

One of the greatest weaknesses of mass educational movements is that they tend to become sloganized and blatant for the sake of attracting attention in an age when every one is clamoring for an audience. Moreover mass movements in health education, as in politics or any other field, tend to attract to themselves the cranks and those with an axe to grind. Such correspondence as the question and answer service of *Hygeia* reveals, in addition to sincere seekers for useful information, those who attempt to abuse the service by trying to get information which they can use against their doctor or to feed their neurasthenic appetites with descriptions of symptoms. Recognizing these dangers, we must guard ourselves against being too much frightened by them. There are physicians who consider that all educational activities should be abandoned because misunderstanding may arise and neurasthenic tendencies may be favored by free dissemination of information. This is the red side of the ledger; on the black side the profits from well conceived educational activities include a better appreciation of medical science, better understanding of difficulties involved in diagnosis and treatment, more skepticism about quackery and charlatanism, greater and more constructive interest in medical progress and scientific research, and livelier appreciation of hygiene, diet and medical supervision in health. The doctor may properly display an unselfish interest in furthering the accumulation of these profits because they are in the interests of the public health.

Assuming that the necessity for health education is admitted and that the part which the medical profession must play along this line is agreed on, what shall be chosen as the best means of accomplishing our purpose? The answer has been given in the organization of public relations committees by state and local medical societies. These committees afford a means of considering objectives, ways and means, and of focusing the attention of the society on educational problems. In some places conspicuous success has been achieved, as the study of appendicitis mortality in Philadelphia proves, especially since the study was promptly followed by a reduction in mortality resulting from practical application of the facts evolved. There is another lesson to be learned from the Philadelphia experience and that is the lesson of cooperation.

Physicians in many instances have found themselves out of agreement with public health workers on the fundamental question of community responsibility for the health of the individual. There is, of course, no disagreement about such community measures applicable en masse as the purification of water supplies and the inspection of milk, meat and perishable foods. Nor is the necessity for health education in the schools and by health departments questioned. These are plainly outside the province of individual effort, and must be done by the community. Particularly in the field of infant health, and more lately in connection with prenatal programs and preschool projects, as well as with immunizations, differences have arisen as to how far the community may go with propriety in promoting the health of individuals without regard to consideration of the financial ability of the persons concerned. I am not discussing the economics of medical practice in this connection. All successful public health work reduces the market for certain medical services, yet doctors have always been diligent in the search for preventive measures against disease and have usually found that bread cast upon the water returns in the form of new fields of preventive medicine opened to the physician.

Aside from the prevention of the communicable diseases, much public health work concerns itself with the problems of individual health, which collectively, of course, are the problems of community health. It is quite possible, and indeed represents the only practical way to accomplish the objective, to control communicable disease through mass measures such as the sanitary precautions enumerated before. It is not possible to promote individual health greatly through such mass measures. The patient with heart disease, with diabetes, the expectant mother, the infant, the potential cancer victim or the child with a physical defect cannot be helped very much by community measures the very existence of which may be unknown to the beneficiary. Typhoid fever can be minimized through protective measures applied to milk, water, foods and carriers, but the person with a noncommunicable disease must be handled as an individual patient. The medical profession has since ancient times held sacred the inviolability of this personal relationship. They do not willingly enter into team play in projects which do not respect it.

The mass methods often adopted in clinics for physical examinations and immunizations are

contrary to the training of the physician and to his proved practice. He knows that the best work for the patient cannot be done that way. In spite of that conviction, physicians have been liberal in their cooperation with projects of this character, giving their services often as individuals and as county societies, because they have conceded that some good might come of the educational effects of mass movements, which have their peculiar stimulating effect on the public mind. The physicians, however, have been disappointed because they have seen undesired though not unexpected results come out of mass methods. Parents of children examined in a group clinic are often misled as to what constitutes a real examination, taking the necessarily superficial screening which is possible at a clinic for an exhaustive diagnostic examination. In a few instances, certificates of good health have been issued to children who were later discovered to have more or less serious disease conditions discoverable by more careful examination. Such experiences tend to discredit public health work, create distrust of medical science in the minds of the public, drive the people to quacks and fakers, and are detrimental to the public health. Our activities in the name of public health must not lend themselves to such misunderstanding. Without denying that something has been accomplished by mass methods, especially in calling attention to opportunities for better health, the medical profession holds that better results could have been accomplished by methods more sound, if less rapid.

There has been too much haste in public health work at certain times and in certain places. The entirely commendable urge to meet a need which appears to be urgent, or the desire to emulate another community in which certain activities are being carried on, or pressure from influential lay groups, or the occasional ambition to make a personal record have hurried communities into activities which they could not afford, and which in due course collapsed. Sometimes the building up of activities for which no real need existed has been encouraged; necessary and commendable things have been done in the wrong way. For example, there is grave doubt in the minds of many experienced public health workers, as well as practicing physicians, whether our elaborate systems of getting corrections of physical defects in school children are effective and economical, and what the true values are in a number of other health activities. We were rushed, not so many years ago, into a frantic hurry to stimulate toothbrush drills in our schools, and we went so far as to furnish toothbrushes in many instances on the theory that a clean tooth never decays. But they did decay, and we had our attention called to persons who never used a toothbrush except to clean the silverware and had perfect teeth—and were our ears red? If we had waited a little, we would have emphasized the toothbrush in a sane manner as we do now, and put more emphasis on diet, and above all, we would have acknowledged that we do not know all about it yet. Doctors who pointed out these possibilities some years ago were pilloried as obstructionists. Today we face a great potential expansion in public health work under Social Security legislation. Doctors are ready to cooperate in all wise and constructive measures under the Act, but would undoubtedly be found opposing were expansion for its own sake.

An instance of the excessive speed at which public health work has sometimes been developed has been premature insistence on full-time health service for every community. As an ideal, probably few would object to that conception. Yet we must recognize that many communities are not ready for full-time health service, and that they could not be supplied with competent personnel if they were. When Wisconsin some years ago had a permissive law for county nurses, many counties took advantage of it. Then the law was made mandatory, and soon all counties had public health nurses. But the law was changed again, back to the permissive form, and very few county nurses remained in the counties which had been coerced into progress. The educational method is slower, but much surer.

"Past history has shown the public health movement largely emanating from the medical profession. And, in the larger sense, it has depended upon the physicians for its application. The anti-tuberculosis, anti-diphtheria, and anti-smallpox movements, the social, infant, maternal and mental hygiene movements, and many others have all been sponsored or supported by organized medicine. Physicians have held the fort as part-time health officers, usually to their own detriment, until the community has been ready for a full-time health officer and an adequately supported department. It has seemed almost axiomatic that the health department must work in harmony with the physicians of the community

and they in turn with the health department."[2]

"The program that has been inaugurated in Detroit," Geib and Vaughan emphasize, "has (1) secured the protection of 70 per cent of preschool children and 80 per cent of school children against diphtheria, without the use of free clinics; (2) reduced the diphtheria death rate to one-fourth of the level existing prior to the beginning of the campaign; (3) provided for postgraduate conferences on communicable disease control; (4) completely changed the attitude of the medical profession toward the work of the health department and, more especially, eliminated the antagonistic feeling that has frequently existed toward the work of the public health nurse; (5) stimulated parental responsibility for the care of the child; (6) provided compensation to physicians for service rendered to the indigent; (7) actually served as a beginning to make a health center of the office of each physician, and (8) afforded an opportunity to expand the program of health conservation with medical cooperation into other fields, such as tuberculosis and cancer control, periodic physical examinations, and the health of mothers and infants."[3]

Leathers reminds us that "The medical profession has been largely responsible for the establishment and extension of public health agencies in this country, and whatever adjustments may be made for providing a more adequate medical service, the maintenance of public health activities on an efficient basis will always constitute a part of the scheme."[4]

The passages just cited evidence the necessity for cooperation between the medical profession and other groups in the community. The doctor cannot stand aloof in his organized capacity any more than he can as an individual. The lay persons who are his patients and whom he meets socially he must also meet in other organized groups as, for example, the women's clubs, the parent-teacher associations, the Y. M. C. A.'s, the church groups, the luncheon clubs and other community organizations. One of the best ways to coordinate community activity is through a community health council, which can do splendid service in preventing waste and duplication, curbing unwise or ill considered activities and focusing attention sharply on problems for which there is a real solution or alleviation. In many places close cooperation between medical profession, voluntary health organizations and lay groups is working satisfactorily; in others it is not. I believe that it is necessary to develop this kind of cooperation to the greatest possible extent in order that the medical profession may retain its rightful leadership in public health.

After all, the idea that the doctor should be a community leader in health is not new. He has always been such a leader. It is necessary only to glance back into the history of development of our boards of health and our voluntary organizations to observe that doctors were important factors in the organization or development of these community services. Doctors have always consistently protected constructive legislation by their influence, and have as consistently opposed unwise legislation affecting the public health. Doctors have defended medical research against the attacks of fanatic cranks. It is only within the last two decades that the lay health educator has begun to overshadow the doctor because the doctor has not seen the necessity for keeping his position of leadership. There is now great activity in the medical profession along lines of health education and participation in public health work. It is important that this activity shall go forward fast enough so as not to be outstripped but not so fast as to make needless errors. It is important that the tried and tested ethical principles of the profession shall not be sacrificed for the sake of spurious advantages in health education. It is important that the personal relationship between doctor and patient be emphasized and maintained. All this requires the sober group judgment of the medical profession and it requires, in my opinion, the organization in every county and state medical society of a committee on public relations and the consistent functioning of such a committee with the full support and understanding of the membership in the society which that committee represents.

It seems to me that there is evidence that physicians and leaders in public health are determined as never before upon a mutual understanding of their common objectives and other common problems. This is not true of all physicians, nor of all workers in public health, but I believe it is true of those who possess the greatest wisdom and the most highly developed ability to sense the best way toward achievement of the highest usefulness for both groups. This way lies through the delivery of the best in public service which both groups have to offer.

It is a privilege to be heard in such a meeting as this and to be able to tell you that the medical

profession looks upon public health officials as natural cooperators for the better health of the American people. Such honest differences of opinion as may arise must and will be settled by calm, temperate and harmonious discussion around the council table. I have just come from such a conference in Minnesota, where the State Board of Health and the Council of the State Medical Society spent a whole day together discussing the implications of social security legislation insofar as it pertains to public health work. I hope there will be many more such conferences because I am sure that out of them will come greater progress in public health and private practice of preventive medicine and their harmonious coordination than through any other method.

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SOME OBSERVATIONS ON FRACTURES SEEN AT FLORIDA STATE HOSPITAL*

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The purpose of this paper is to present a few of our observations on fractures that have occurred at the State Hospital, particularly among the mentally ill and with especial emphasis on those fractures occurring in the region of the hip.

The problem of treating fractures in the mentally deranged presents a more difficult one than that met with ordinarily. This is due to the fact that in addition to the fracture, we have a patient who is often entirely irresponsible, unreasonable and uncooperative. On the average we probably get poor results more frequently but everything considered I think they are surprisingly good in view of the type of patient with whom we deal. However, a few of our patients are exceptionally cooperative.

Many of the things that I shall mention are doubtless familiar to all of you but I believe they are important enough to be worthy of repetition.

From July 1, 1930, to July 1, 1935, our records show that there have been treated at the State Hospital a total of 303 fractures of all types, or an average of five per month. Around 10% of these fractures occurred in employees and a few of the 10% were acute emergencies from auto accidents on the local highway.

You will note the chart gives the total number of each type of fracture for the year as well as the total of each type of fracture for the five-year period. You can see that this classification is rather indefinite with reference to some types of fractures—*i. e.*, some are classified as Colles' fractures and Potts' fractures and others are classified as fractures of radius and ulna or tibia and fibula, when they are probably identical types. I believe we should get entirely away from such terms as Colles' fracture, Potts' fracture, Barton's fracture, etc., and that fractures should be accurately described according to their exact anatomical location on the involved bones. A Colles' fracture may mean one thing to one person and have an entirely different meaning to another person and the exact location of the fracture vary in our minds by several centimeters, involving one or two bones to different extents.

I will first discuss fractures in the region of the hip (upper femur), which you will note occur more often than any other one type, both per year and for the five-year period with an average of one per month. This type of fracture has been our greatest problem from the standpoint of mortality as well as from that of relieving pain and obtaining a functional result.

The large majority, about 80% of our fractures of the femur, have been either intertrochanteric or fractures of the neck. Several were unclassified and would probably fall into one of the above classifications and three out of the total were pathological.

These fractures practically all occurred in our older patients, the average age being sixty years and many of them being in the seventies and eighties, the average for all being lowered somewhat by the occasional younger patient. Out of our population in the institution on July 1, 1935, we had 690 patients who were sixty years of age or above.

The mortality in fractures of the femur for the five-year period has been about 47%. As best I am able to determine the usual average

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FRACTURES TREATED AT FLORIDA STATE HOSPITAL, 1930-1935

Year July	Carpal	Patella	Mandible	Pelvis	Ribs	Tibia and Fibula	Tibia	Radius and Ulna	Metatarsal	Fibula	Potts	Ulna	Clavicle	Colles	Radius	Humerus	Phalanges	Metacarpal	Femur	Yearly Total
1930 1931	1	..	..	..	..	1	2	1	..	1	..	2	2	7	5	2	3	4	10	41
1931 1932	..	..	..	..	..	1	2	..	2	2	4	3	4	2	9	4	2	4	12	51
1932 1933	..	1	..	..	1	1	1	1	3	1	8	..	6	5	..	8	6	9	10	61
1933 1934	..	..	1	..	..	..	..	3	..	3	..	5	6	9	4	4	6	5	15	61
1934 1935	1	1	1	2	3	4	2	2	4	4	..	4	4	1	7	8	12	14	15	89
Total	2	2	2	2	4	7	7	7	9	11	12	14	22	24	25	26	29	36	62	303

for this type in the aged is around 20% to 25%. At first glance our mortality appears to be extremely high but we must consider that in addition to the age these patients are also mentally deranged and are usually debilitated with cardiovascular-renal complications. Also this mortality is calculated from the total regardless of the condition of the patient, the fracture in at least five of the above contributing in the course of metastatic carcinoma or pulmonary tuberculosis. Regardless, I consider the mortality much too high.

The treatment in the majority of these patients up until January, 1934, consisted in the use of the Buck's extension and sandbags, an occasional suitable case being treated with traction frames and in plaster casts. Since that time we have endeavored to work out some more satisfactory form of treatment. I do not consider the Buck's extension in any way a scientific method of dealing with this type of case and believe it is seldom if ever indicated if any other form of treatment can be devised. The pain is not relieved, the mortality is extremely high, complications more frequent, and there are usually poor functional results when the patient survives.

Let me say that I do not imply criticism of anyone who so treated these cases. You must remember that our Hospital is primarily for the mentally ill and time is lacking for the treatment in detail of some things. Adequate and successful treatment of fractures requires much time, attention to detail, and accumulation of apparatus, which was not then available. It has been necessary that our apparatus be collected gradually and we are still lacking in many essential things. Traction frames have been tried and proved to be unsatisfactory except in a very few cases. The majority of mental patients do not cooperate well; they will continually displace and remove portions of such apparatus which requires constant readjustment. There is also limited chance for change of posture, which predisposes to hypostatic pneumonia.

It has also been my experience that these aged individuals do not get along well in plaster casts. Many are extremely untidy, necessitating frequent changes of casts with added exertion and strain on the patient and with the possibility of disturbing union or bony relations of the fracture. The sense of restraint is greater in the use of the cast, which usually aggravates the mental condition. Our facilities for the proper application of this type of cast are somewhat poor and I believe unless the cast is properly applied its usefulness is nil.

For the past several months we have used the Roger Anderson well leg splint and I believe it has solved our problem; although my experience with this apparatus is limited, and entirely limited to use in intertrochanteric and fractures of the neck of the femur, the results have been very satisfactory thus far. We have in this apparatus a fixation that is positive and cannot be removed by the patient. They may be turned in bed frequently, may assume the sitting position or even be placed in a wheel chair and rolled on the porches, which if not improving their mental condition at least does not aggravate it.

Some of our patients have complained of pain

for a few days after application of the apparatus and then have apparently been fairly comfortable. Early and immediate reduction is possible, lessening the pain and subsequent shock and these aged persons do not tolerate pain well. We have not found it necessary to change the casts or use any further manipulation once the fracture is reduced. In applying this splint we have followed implicitly the directions given. Doubtless the majority of you are familiar with the details of this apparatus. However, I wish to review briefly the principles of this splint, quoting Dr. Anderson on "The Well Leg Counter Traction Apparatus":

"The well leg is utilized for counter traction.

"1. Apply cast to well or uninjured leg from beyond the tips of the toes to mid thigh. (The foot is at right angles to the long axis of the leg and in position of slight eversion. The cast is well padded, especially over the sole of the foot, at which point a strip of felt is used. The cast must be accurately molded to the sole of the foot to prevent areas of increased pressure. The cast is cut out over malleoli, patella and tops of toes.)

"2. Incorporate well leg portion of splint in cast.

"3. Insert Steinman pin through tibia at two finger breadths above the internal malleolus. (A sterile field is prepared with iodine and 2% novocaine injected as local anesthesia; sterile gauze is spiked over each side of the pin.)

"4. Apply cast to injured leg from beyond tips of toes to five inches below knee joint, incorporating the pin in the cast. The leg is, of course, first well padded.

"5. Attach splint, exert traction by screwing down traction nut and correct rotation by adjusting rotation nut.

"When the lever arm on the apparatus is at right angles with the longitudinal axis of the legs, sufficient traction has usually been exerted.

"The head and feet of the patient are drawn to the injured side and the hips displaced to the opposite side, permitting the spine to set at right angles on the pelvis.

"The process of reduction must be checked by x-rays (anterior and posterior, lateral or stereoscopic) views until reduction is complete.

"Fractures of the neck of the femur require little traction and each week traction may be decreased to that point where alignment is still maintained. Internal rotation is increased slightly in fractures of the neck.

"Before application of the splint it may be unbolted into three parts: (1) The counter traction portion, (2) the lever and screw rod, and (3) the traction portion."

We give our patients a preliminary hypodermic of morphine and repeat if necessary or give it in conjunction with other drugs if much disturbed. With the use of 2% novocaine at the point that the pin is inserted none have suffered any apparent discomfort. We have found the apparatus to be rather powerful and sufficient traction is easily obtained.

One feature which appeals to me is the ease with which this apparatus is applied, it being unnecessary to move the patient from the carriage during the entire process.

Since we have used extensively other methods than the Buck's extension we note a drop in our mortality from 50% in 1930 and 66% 1931-32 to 33% in 1935. We do not attribute this entirely to the use of the Well Leg splint as we have only used it in a few recent cases, but we do attribute it to the use of these other methods.

I believe that all fractures of the femur in the aged should be intelligently treated regardless of their weakened condition and the probability of a fatal outcome. If we feel that they cannot survive the treatment we can feel almost positive that they cannot survive without treatment and we can know that the extreme pain in the last days was lessened.

In regard to other types of fractures in mental patients we again find that fixation must be irremovable or as nearly so as possible. For this reason circular plaster casts are applied in all fractures of the extremities. We have had relatively little excessive swelling and I do not recall a case in a fracture that was treated early in which it was necessary to bivalve the cast. However, all cases with circular casts are routinely ordered to be observed at frequent intervals for any cyanosis, swelling or extreme pain in the extremity.

After application of the cast the extremity is immediately elevated to a plane higher than the body for 48 hours or longer. The use of circular casts is a necessity with us but I consider it definitely contraindicated unless the patient is under constant observation.

The preparation of the skin before application of a cast is, I believe, too often neglected. We routinely cleanse the skin with soap and water, alcohol or ether; dry well and powder, even with the simplest type of fracture. With this prepara-

tion the condition of the skin is surprisingly good even after the cast has been on for some time.

The right amount of padding under a cast or splint is a very important point. I believe we often err on the side of too much rather than too little padding, which causes inadequate fixation. The right amount comes with experience and with little padding the plaster must necessarily be accurately molded to conform to the contour of the extremity and there must be no indentations.

On the majority of our patients we are unable to institute massages, heat therapy and early motion. This would mean daily applications of casts which is, of course, impractical. Our policy is to keep them in a cast until union is fairly solid and then institute the above therapy. Our results as a rule have been quite good and I believe are largely due to the fact that many of these mental patients will continually attempt to carry out motion in the part.

Impacted or compression fractures of the radius frequently occur in our elderly patients resulting from falls. I think that often we tend to let this type of fracture go without reduction even when there is obvious displacement, much to our regret later. It is said that the safest rule is to reduce them when in doubt and at least attempt to dispel the probability of a prolonged disability and painful wrist.

In regard to anesthesia, I am sure we all realize that an anesthetic of some type is absolutely essential to a proper reduction. I am guilty, and I expect most of us are at times, of attempting a reduction without an anesthetic, usually causing the patient unnecessary pain and getting exactly nowhere ourselves.

In some of our patients we have had fair results with local anesthesia in conjunction with other sedatives or hypnotics. We use this largely in elderly or debilitated patients who would not stand a general anesthetic without risk. Our technique is similar to that advocated by Bohler—prepare a sterile field, anesthetize the skin and inject 10 to 50 cc. of 2% novocaine between the bone fragments. As a whole we have not found local anesthesia satisfactory in mentally upset patients as they are often uncooperative and resistive, even when the pain has disappeared.

You will note that fractures of the metacarpal and phalangeal bones are fairly common. These occur usually among those patients who are violent and result from striking other patients or objects with the closed fist. They often re-occur in the same patients numerous times.

Fractures of the clavicle are fairly common and in a disturbed patient are most difficult to treat. I have yet to find a satisfactory method of immobilization and am open for any suggestions.

You will note that the fractures that have occurred at the State Hospital have more than doubled for the five-year period, having a total of 41 in 1930-31 and a total of 89 in 1934-35. The only explanation I can give for this is lack of adequate supervision of our patients and overcrowding, which of course, throws the patients in closer contact and makes the supervision they have more difficult to carry out.

The population of the institution in July of 1930 was 3,407 and the actual number of attendants supervising patients on the wards was 295. The population of July 1, 1935, was 3,865 patients with 303 attendants, showing an increase of 458 patients and a corresponding increase of only eight attendants with no increase in accommodations or facilities for segregation. Unless these conditions are remedied we can, I believe, expect a continued increase in fractures at the State Hospital.

SUMMARY

1. The treatment of fractures in the mentally deranged presents more of a problem than those encountered in normal persons, and the results are often doubtful.

2. Fractures of the upper femur predominate at the State Hospital, the majority occurring in those sixty years of age and above, and all such cases should be scientifically treated.

3. The Roger Anderson Well Leg Splint appears to us to be the most satisfactory form of treatment for our patients.

4. Circular plaster casts are a necessity in fracture of the extremities in the mentally disturbed and may be safely used provided they are properly applied—the part elevated, and the patient under constant observation.

5. Such measures as heat therapy, massages, etc., must often be delayed in treatment of fractures in disturbed psychotic patients.

6. The number of fractures among patients at the State Hospital have more than doubled in the last five years. A further increase may be expected unless adequate supervision and proper segregation can be arranged.

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THE TREATMENT OF TUBERCULOSIS*

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I was born in a doctor's home in the red hills of South Carolina. As a small boy, one of my first memories is of the time when my father came home announcing that one of my schoolmates had appendicitis. The surgeon was called from a city some distance away. He brought his instruments, sterilized them on the kitchen stove and did the operation on the kitchen table. The girl lived only a few days. During those same days, my father often came home announcing that some patient had tuberculosis. Afterward it was merely a matter of time until he came home again announcing the death of the patient. There were no sanatoria in our state during those years. Neither were there many men able to make an early diagnosis of the disease. Today, surgery has made great advances and our state has a well-equipped sanatorium and several county institutions. I represent one of these latter which is owned and operated by Florence and Darlington Counties.

Treatment, in tuberculosis, depends in a large measure upon early diagnosis. In fact, this is usually one of the easiest of all diseases to treat when early diagnosed. Later it becomes one of the hardest. Upon this fact depends our campaigns in tuberculin testing followed by chest examinations and these by x-rays of the chest of those reacting to the tuberculin.

The sanatorium plays a great part in the treatment of tuberculosis. Here we isolate the patients from other members of the family. They are placed in similar groups with regard to the severity of the infection. Each patient finds himself or herself among people who are undergoing similar treatment. In our sanatorium, these patients are always given surgical treatment at once where this is indicated.

There are only a few things which the patient can do in the matter of getting well. However, these few are very important. He can eat and remain in bed according to directions. It is very necessary that he use care to cover the mouth and nose when coughing. This is to protect those around him. Above all, it is very necessary that the patient become reconciled to the treatment and keep himself mentally content. The mal-contents, in any sanatorium, are the ones who rarely respond properly to treatment. They often interrupt treatment by leaving the sanatorium and later die of tuberculosis.

In the old days, we always said that the treatment of tuberculosis depended mainly upon three things, viz: rest, fresh air, and diet. To this we added a few medicines. Today, the answer is still the same but it means something quite different. We still place our patients in bed and still keep them out in the fresh air at all times. However, the great difference is in the matter of rest. Where we formerly placed the patients in bed and left them there to get well or die, we now think of surgery first. In every case where some type of collapse therapy is applicable, we use this at once. We do not wait to see what rest in bed will do. After deciding that some form of collapse therapy can be used, we begin it at once. There are only two types of cases where surgery is not used at once. These are the minimal lesions, where we do not care to subject the patient to the treatment, and the other is the far advanced case upon which we do not dare operate. The first case I wish to present is of a young lady who was a student at Coker College. During a recent tuberculin test, she was found to be positive to the test. Physical examination revealed a slight lag on the right side with some dulness in the extreme apex. The x-ray showed a small amount of infiltration above the clavicle and in the first interspace. This girl was brought into the sanatorium and given rest in bed. The second x-ray showed her apex almost perfectly clear after four months of this treatment.

In considering surgery, our first thought is pneumothorax. Wherever this is applicable and can be used, we never think of other treatment. Pneumothorax means air in the chest. You will remember that the lungs are attached at the hilus and that each lung is covered by a layer of pleura. This pleura is reflected back over the chest wall, making what is potentially a space between the lung and the chest wall. It is here that we introduce air to close the diseased lung. The ideal place for the use of air is in the chest where one lung is diseased and the other free of disease. However, we do use it where there is a small amount of disease in the contralateral lung. At times we use partial collapse

*Presented before the Florida Tuberculosis Association, Orlando, April 3, 1935.

of both lungs. This treatment has the disadvantage that fluid often forms in the pleura and causes discomfort. Rarely, the fluid becomes infected and this causes more discomfort. There is also some danger in the treatment. Very rarely we see a case of pleural shock or of air embolism. Fatalities are very rare and certainly should not prevent our using the treatment wherever possible.

Case 1. A middle-aged man, worker in the railroad shops, had suffered from diabetes for eight years. Six months previously he found himself losing weight and went to the railroad hospital for an examination. The x-ray showed an advanced case of tuberculosis involving a large portion of the left lung and with a small amount of involvement in the right side. Pneumothorax was instituted at once. A complete collapse was obtained. The last x-ray was made at the time of discharge from the sanatorium. It showed the left lung completely closed and the right well healed.

Case 2. A young lady who was a senior at Winthrop College began to notice that her afternoon temperature was above normal. The x-ray showed an infiltrative lesion in the left base. Physical examination indicated that there was possibly cavitation in this base but this could never be proved by the x-ray. This girl had a total white blood count of approximately 19,000 cells. The poly count was also greatly elevated and was at one time 88%. Pneumothorax was given at once. All symptoms ceased and the blood count promptly returned to normal. The last x-ray showed a perfect collapse of the left lung. At present, and after four years, this lung is re-expanding.

Case 3. A boy of 13. He was a student at the deaf and dumb institute which we call Cedar Springs. He entered the sanatorium with a temperature of 103. The x-ray showed widespread involvement of the left lung. There were numerous cavities in the lung. Only a small amount of disease could be seen in the right lung. This child was given pneumothorax at once. The last picture shows a perfect collapse. The child remained in the sanatorium for eighteen months. He is now at home and in good condition. He still takes air at two-week intervals.

Case 4. A young lawyer developed a cough and slight fever. The x-ray showed a lesion in the left apex. Just beneath the clavicle was a small cavity. Pneumothorax closed the lung perfectly except for one long stringy adhesion in the region of the cavity. Pneumolysis was considered for the removal of this adhesion. It was later found to be unnecessary. The last film showed the collapsed lung with what remained of the stringy adhesion. The man is back at work and is taking refills at three-week intervals.

Case 5. A farmer, and a member of one of the finest families in Darlington County, was treated for months for a trench-mouth. Finally his disease was recognized and he entered the sanatorium with a temperature of 101. The x-ray showed a pneumonic lesion involving all of the upper lobe of the right lung. There was a cavity the size of a half-dollar in the center of this lobe. Air was given at once and the base of the lung closed perfectly. However, there were two large band-like adhesions over the apex. The other lung remained fairly free of disease and all symptoms abated. The man went home for the funeral of a relative. When he returned, three days later, the pleura had filled with fluid. This increased and was removed many times. Finally, a phrenic neurectomy was done in an attempt to stop the fluid. The last x-ray showed the final result. All fluid is gone but the man continues to take air each two weeks.

Case 6. A young nurse came in with high fever. She had been neglected and her disease overlooked. The x-ray showed involvement of the entire right lung and a small area in the left base. She was given air the morning after admission. The closure was not good because of adhesions. Some of these were to the diaphragm and a phrenic neurectomy was done in an attempt to close the lung. This girl is still in the hospital. She gets air each two weeks and we may still have to do an intra-pleural pneumolysis to remove other adhesions.

Case 7. An old lady from the farm, her hair was almost perfectly white, had been treated for malaria for years. The x-ray showed a large cavity in the right base. Her high fever came down to normal promptly after pneumothorax was instituted. However, the basal cavity failed to close and a phrenic neurectomy was done to close it. The last picture showed the cavity closed. The lady has been back at home for more than a year. She gets refills at three-week intervals.

Bilateral pneumothorax is used at times. Here the lungs are only partially closed in each instance. We use this type of treatment rather infrequently but have had some good results from it.

Case 1. A little negro girl, age 13, on admission had a lesion involving all of the left lung. There was a small cavity in the middle of the right lung. Air was given in the left side and a perfect collapse obtained. After three months, the child again began to run an afternoon temperature. The second x-ray showed the cavity enlarging and extending outward. Part of the air was removed from the left side and air introduced into the right side. Both lungs were kept partially collapsed for five months when we lost the space on the right side. The x-ray at this time showed the lesion well healed. At present, air is given in the left side at three-week intervals.

When there is too much disease in the two lungs for air to be used in either or when the pleura is adhered so that we cannot get into the pleura, we think of a phrenic neurectomy. There is one phrenic nerve on each side of the neck and these pass downward supplying in each instance one leaflet of the diaphragm. When a nerve is cut, that side of the diaphragm becomes paralyzed, rises upward and does not move again. Two types of operation are done at present. At times the nerve is crushed, giving a collapse which lasts for about six months. In the others, the nerve is not only cut but avulsed causing a permanent paralysis of the diaphragm.

Case 1. A young insurance man. On admission, his x-ray showed a cavity the size of a silver dollar in the right apex. He refused pneumothorax and also a phrenic neurectomy for some time. Finally, when done, the x-ray showed the cavity well closed. The man is back at work.

Case 2. A young woman who was a stenographer. The x-ray showed a cavity the size of a fifty-cent piece in the left apex; the right lung was clear. She refused pneumothorax and also the phrenic operation. The cavity closed perfectly while in bed for six months. However, as soon as she was put on exercise, the fever returned and the x-ray showed the cavity enlarging. A phrenic neurectomy was then done. This closed the cavity and it has remained closed. The girl has been back home and at work a number of months.

Case 3. This young man was an electrician. He first went to the Adirondacks for a year. His first film, made there, showed widespread disease in the right lung with a large apical cavity. There was an area of disease the size of the hand in the middle of the left lung. The next picture, made at the time he came to us, showed two large cavities in the right lung. There had been some healing in the left side. A phrenic neurectomy was done soon afterward. Both cavities closed with the exception of a very small dime-size cavity beneath the clavicle. A little fever remained and there was a little sputum. A scaleniotomy was done on the right side. The last x-ray showed all cavities closed. The man is clear of all symptoms but is still under treatment.

Case 4. Young white male, age 23. This man came in with high temperature and a history of many hemorrhages. His x-ray showed a large cavity the size of an orange in the left apex. In the right apex was another the size of a lemon. The disease was fibroid in type. This man was placed in bed for nine months. The smaller cavity was then closed. A phrenic neurectomy was done on the left side and it closed the larger cavity. This man has been at home more than two years and continues in good health.

Case 5. A young woman from the farm. Her x-ray showed considerable bilateral disease. There were two cavities in the left lung. A phrenic neurectomy was done on the left side. The patient remained in the sanatorium for a year. The picture at discharge showed both lungs well healed and the cavities closed.

Everyone who treats tuberculosis soon is faced with some patient who has had pneumothorax and has lost the space. A phrenic neurectomy has been done but still one or more cavities remain. If only one lung were diseased, a thoracoplasty would be the operation of choice. However, in many of these cases there is bilateral disease and such an operation is impossible. Some men have opened the chest over the cavity and used various materials to pack above it. The following have been used: fat from other portions of the body, gauze and paraffin. The paraffin used here is one which is specially prepared and melts at fifty degrees centigrade. In recent months, a number of such patients have presented themselves at our clinic and in each case have had paraffin pneumolyses.

Case 1. A young physician has been in the sanatorium for about eight years. A few months ago, he returned home. He continued to expectorate and to have fever from time to time. Note that this man has had pneumothorax for one year. Later a phrenic neurectomy was done. The first x-ray showed a large cavity beneath the second rib in the left side. There was widespread disease in this apex and also some in the right lung. There was a small

cavity in the mid-portion of the right lung. About two inches of the rib was removed in the left axilla and paraffin packed over the large cavity. The last film shows the large cavity almost closed. Symptoms have been relieved and this doctor is at this minute giving artificial pneumothorax in my sanatorium.

Case 2. A young man from your State of Florida. This man came in with bilateral disease. The first film showed a large cavity in the right apex. There was considerable soft disease in the left apex. A phrenic neurectomy was done on the right side. The second film showed the cavity almost closed. At that time, the man was greatly improved but he was at home and refused to take care of himself. Fever and cough returned. The next film showed the cavity enlarging and the disease spreading in the left apex. Realizing that the case was hopeless without surgery, many attempts were made to give air in the right side. All failed and the man continued to grow worse. Paraffin was suggested and the operation done. The last film shows the cavity closed and the left side again improving.

Case 3. A young man, worker in a paper mill, came in with advanced bilateral disease. Soon afterward, he developed a pleurisy with effusion on the right side. This cleared and hemorrhages began from the left apex. Finally there was great improvement in the right side but a cavity began to form in the left apex. A phrenic neurectomy was done in the hope of closing it. It failed and pneumothorax was tried many times and this failed. All the while there was continued improvement in the right side. Finally paraffin was packed in the left apex. The last film shows the cavity well closed and there is a perfectly good breathing base beneath the paraffin. This man is improving at present.

Only one mention has been made of the intrapleural pneumolysis. No cases of thoracoplasty have been presented. This has been done because you have a surgeon to follow on the program and I feel that he will want to cover these subjects. It is for this reason that I have omitted them.

In closing, please let me say that I have presented a rather routine series of cases from our sanatorium and clinic. Please allow me to again stress the fact that we always use some type of collapse therapy wherever possible and that we use it early. If this is to be the treatment there is no earthly reason to wait. Waiting gives the disease time to spread. It allows adhesions to form and thus prevents the use of this type of treatment.

The cases of paraffin pneumolysis are new in our state. We know of no one who has done these here before. We feel that this type of operation has a definite place in our work. In properly selected cases, they will save lives which would otherwise be lost.

No medicines have been mentioned. We always use codeine for the cough. Recently, we are using insulin in small doses where the appetite is poor and other remedies fail. Calcium chloride is used routinely where there is intestinal tuberculosis. Laxatives are frequently needed and we use liquid petrolatum or other mild cathartics.

PYELITIS IN PREGNANCY*

I. J. Strumpf, M.D.,
Jacksonville.

Whenever obstetrical complications are mentioned the first thoughts which usually flash into mind are ones of eclampsia, or placenta previa or tubal pregnancy. One is prone to forget that as horrible and dramatic as these complications are, they comprise but a small fraction of the dysfunctions to which the pregnant female is heir. Less spectacular but certainly more frequent are the complications involving the female urinary tract. Approximately 3% of obstetrical cases are complicated by infection along the urinary conducting system. This figure is within the range reported by many representative clinics throughout the country. Because of this high incidence pyelitis complicating pregnancy is now receiving in the literature considerable attention from obstetricians and urologists.

In pyelonephritis not associated with pregnancy, the characteristic x-ray picture of blunted calyces, enlarged pelves, kinked, tortuous, displaced and dilated ureters has long been known and the extent of the pathology roughly determined from the plate. While this may be true of x-rays of pyelonephritis in the non-pregnant female, the pyelograms taken during pregnancy are unique.

Using the retrograde method of pyelography, Kretschmar and Heaney showed that pregnant women without symptoms of urinary tract disease exhibited x-ray findings quite similar to the findings in clinical cases of full-blown pye-

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litis or pyelonephritis. Duncan and Seng further showed by the same method that the ureters and kidney pelves of pregnant women dilated as early as the sixth week and that involution of these dilated structures occurred following the termination of the pregnancy. The use of the retrograde method in studying the pyelography of the normal kidney of pregnancy was a questionable procedure because of the ever present possibility of introducing infection into the urinary tract by a possibly unwarranted cystoscopy and ureteral catheterization.

With the advent of the intravenous dyestuffs, like skiodan and iopax, about 1930, this objection was removed and the literature from all parts of the globe was enriched almost immediately: Shumacher, Greume, Guthmann, and Ehrhardt in Germany; Dugald Baird in London; Mengert and Lee, Cornell and Warfield, Crabtree and Prather, Kretchmer and Heaney, and a host of others contributed to the literature in this country. The results of all this investigation to date showed that in at least 92% of all normal, symptomless, controlled pregnancies there will be found on x-ray, blunted calyces, enlarged pelves, hydro-ureters, kinked, deviated and tortuous, almost indistinguishable from the pictures of those obtained in definitely pathological cases; that although more frequent on the right side, the left ureter also is involved in the change and that the dilatation is most marked above the brim of the pelvis. Furthermore, all those women who went through their lying-in period without complication showed in postpartum plates, involution of these dilated structures apparently to normal size. Those who developed infection during the lying-in period showed delayed involution in the postpartum plates. (Braasch, Crabtree, Kretchmar, Morris, and Langlois). Hand in hand with this atony of the urinary structures there is considerable evidence tending to prove that it is but a part of a generalized, smooth muscle atony coincident with pregnancy. Gellhorn and Alverez, working on the intestinal tract, Higgins with gall-bladder, and Kilbourne with varicose veins have demonstrated this smooth muscle relaxation coincident with pregnancy. But, whatever the cause, whether the dilatation in the urinary conducting system occurs because of pressure from a growing uterus, as advocated by Crabtree, or intravesical edema with constriction (Baird), or the torsion of the uterus with stretching of the left ureter and kinking of the right ureter (Cumston), or thickerning and hypertrophy of the juxtavesical portion of the ureter (Hofbauer), or a relaxant or hormonal effect (Hundley), it is interesting to note that this dilatation takes place sometimes as early as the sixth week, before the uterus is large enough to cause compression anywhere near the ureter, and before torsion occurs. Also that larger and harder pelvic masses, such as fibroids and ovarian cysts and bony, chronic parametritic exudates extending from pelvic wall to pelvic wall occasionally cause urinary tract obstruction but without the coincident hypertrophy of the muscular and fibrous elements and without thickening of the sheath of Waldeyer. The importance of this finding of almost universal dilatation in normal, symptomless pregnancies is obvious from several standpoints. First, the roentgenologic appearance of the urinary tract during pyelitis in pregnancy is no true indication of the extent of the pathological process, and that the indications for operative intervention in such a pregnancy must of course be based on clinical and functional criteria, and not on x-ray. Light is likewise thrown upon the etiology of the frequency of pyelitis during pregnancy, because here is graphic evidence of a dilated pelvis, a dilated, atonic ureter with a sluggish urinary stream subject to easy infection whether from a focus from carious teeth so frequent during pregnancy, or by transmigration of B. coli through an intact bowel wall in the very common chronic constipation of pregnancy, or from some other source.

Treatment.—Although treatment properly belongs in the field of the urologist and early liaison between the obstetrician and the urologist, in the common interest of the patient, should be resorted to; early and frequent urinalysis will often detect the initial bacteriuria or pyuria indicative of early infection even before pyrexia occurs. At this stage, alkalinization of the urine with an abundance of citrus drinks, bicarbonate or citrocarbonate of soda in good-sized doses (180 grains daily), forcing of fluids to the extent of at least ten glasses a day, and frequent changes of position to favor drainage should be encouraged. Subsequent acidification of the urine with acid sodium phosphate, ammonium chloride or nitrate and the administration of the formaldehyde splitting drugs like urotropin, urophosphates, formohydrion, hexelet or cystogen will in most cases adequately take care of the mild case. As the efficacy of this group depends upon the antiseptic action of formaldehyde split off

in acid urine in the pelvis of the kidney, fluids should be limited to less than 1000 cc. daily during the exhibition of this type of medication; otherwise the very purpose of the antiseptic is defeated by simple dilution. Conversely, the pushing of excessive doses is very apt to cause diffuse glomerular irritation and the appearance in the urine of red cells. Adequate amounts can be gauged by testing the urine with sodium nitroprusside and phenyl hydrogen hydrochloride for the first appearance of urotropin.

With mixed infections, drugs like caprokol, pyridium, mallaphene, helmitol, niazo or serenium may be used with greater or lesser effect. If, during the exhibition of urinary antiseptics, it is found that clinical relief and drop in temperature is not obtained promptly, it would be wise to change the antiseptic or adopt a new line of therapy. In medically intractable cases, or cases where oral or hypodermic administration of antiseptics excreted by the kidney are not well borne, prompt ureteral catheterization and drainage of the kidney pelvis should be instituted. With free drainage via the ureteral catheter, patients have been carried along and delivered of full-term living children, which otherwise would have been sacrificed to save the mother. One of a series of such cases comes to mind of a 22-year-old primipara who developed a right-sided pyelonephritis, intractable to all types of medication and as a life-saving measure, ultimately came to induction by bag and delivery of a seven-month fetus who succumbed shortly. Two years thereafter she again came under observation, again pregnant and again running the clinical course of a severe right-sided B. coli pyelonephritis resistant to all forms of antiseptic medication. This time she was catheterized and a number 8 ureteral catheter left in place. There was prompt clinical improvement. She was catheterized four times between the seventh month and the time of delivery, catheters remaining in place on one occasion for 72 hours, the renal pelvis being irrigated with normal saline. Following each catheterization there was a spectacular drop in her temperature. She was subsequently delivered of a full-term living child.

Occasionally bacteriophage may be instilled into the renal pelvis through the ureteral catheter and the catheter clamped. Although favorably reported upon in the literature, there is an obvious disadvantage involved in the preparation of bacteriophage.

The induction of premature labor following ureteral catheterization is a relatively infrequent event and this procedure is fairly safe with a moderate amount of care, particularly if it has been preceded by the administration of morphine.

Following delivery these cases may not be neglected because of the high incidence of reinfection in subsequent pregnancies, as brought out by Walther and Willoughby and Crabtree and Prather and Trout. Medical treatment must be vigorously persisted in until the urinary sediment has been consistently clear. Further pregnancy should be advised against until this happy termination is reached. Hofbauer advocated the routine use postpartum of pituitary extracts, hoping to stimulate the tonus of the ureteral musculature to more rapid and complete involution.

The realization that pyelitis in pregnancy is common and not to be taken lightly, that treatment should be prompt and effective, and that the urologist and the obstetrician together have means at their disposal to control this complication, are factors which will reduce the incidence of those unfortunates whose pregnancies have had to be terminated because of a fulminant pyelitis.

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TRAUMA AND APOPLEXY

The etiology of intracranial hemorrhage may be obscure, especially when there is a history of head injury, in a patient with cardiovascular disease and hypertension. The medico-legal aspect may be a point of issue should there be insurance involved to cover accidental death or disability.

By apoplexy is meant a deep-seated intracerebral hemorrhage or vascular lesion associated with disease or anomaly of a blood vessel in the brain and not due to external violence. It is usually situated in the internal capsule and produces a hemiplegia. From the clinical standpoint it is not easy to tell whether it is due to a vascular rupture or occlusion due to a thrombosis or spasm of the vessel. On postmortem examination the differentiation is not always easy, since in thrombosis there may be hemorrhagic extravasation in the ischemic zone by the process of diapedesis of the red cells through the altered vessel.

Hutcheson[1] in a recent article stressed the fact that frequently apoplexy occurs while the patient is in bed asleep when the blood pressure should be at its lowest point, making the conditions least favorable for a vascular rupture. This, however, may be an argument in favor of vascular occlusion due to thrombosis rather than hemorrhage. Many text books emphasize the point that stress, strain and physical exertion tend to raise the blood pressure and are the frequent causes of a cerebral hemorrhage. As a matter of fact apoplexy does not occur any more often under these conditions than when the patient is quiet and at rest.

Bouman[2] discussed intracranial hemorrhage from the etiological standpoint and gave the views of different men as follows: Charcot in 1868 considered cerebral hemorrhage was due to the rupture of a miliary aneurysm which was frequently encountered in the vessels of the brain. Lowenfeld in 1886 found degenerative changes in the media of the vessel in the center of the apopletic lesion. Pick in 1910 found Charcot's aneurysms but did not believe they were responsible for the fatal hemorrhage. He found larger dissecting aneurysms associated with arteriosclerosis, the rupture of which he believed was the cause of a large hemorrhage. Rosenblath in 1918 presented a new idea that the hemorrhage was caused by a secondary rupture of the vessel in an area of altered brain tissue and necrosis due to some unknown toxin. In the peripheral zone of the large hemorrhage were numerous little hemorrhages from rupture of many little vessels. Staemmler in 1927 studied traumatic brain hemorrhage and necrosis due to bullet wounds and found similar little hemorrhages in the surrounding zone. Bouman in 1931 confirmed these findings in his report. Ruhl in 1927 found atheromatous ulcers in the wall of the vessel and he believed the hemorrhage was caused by the rupture of these vascular lesions. He thought the destructive power of the blood clot was sufficient to cause the necrosis of the smaller vessels and little hemorrhages found in the periphery. Globus and Strauss[3] believe the hemorrhage was primarily caused by a focal or generalized arteriosclerosis of a cerebral vessel with narrowing of its lumen, and that this produced ischemia and softening of the brain which removed part of the vascular support and caused it to rupture.

It may be a mooted question whether a brain injury such as concussion can tear loose the neurogliar attachment of a cerebral vessel, thereby weakening its wall and allowing it to rupture several days later. A patient with a known vascular disease may fall down the steps or off a scaffold with apparently no serious head injury and later develop a hemiplegia. Whether the hemorrhage was caused by the injury or the result of natural causes will be of much concern to the responsible parties involved.

In the differential diagnosis it will be necessary

to exclude an extradural hemorrhage which is frequently associated with a mild head injury. In this condition there is usually a fracture of the skull in the temporal region which lacerates the middle meningeal artery and there are the clinical symptoms of compression. In subdural hemorrhage the clot is extra-cerebral and the spinal fluid may show some blood staining. There will also be clinical symptoms of compression the onset of which may be delayed for weeks or months. In apoplexy the vascular lesion is deep seated in the brain substance and usually there is no great increase in intracranial pressure unless a massive hemorrhage is present.

There are numerous factors involved in many cases and the physician should weigh carefully all the facts before making his final diagnosis.

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STATE NEWS ITEMS

Dr. C. W. Shackelford, West Palm Beach, was the principal speaker at the Rotary Club luncheon held at the Salt Air Hotel recently. Dr. Shackelford's subject was "The Work of the County Physician." He brought out that among other things, the county physician visits schools, hospitals, the county jail, the children's home and the county home. Four hundred thirty-five charity cases were cared for at the hospitals last year. Doctor Shackelford mentioned the fact that the county health department and other health agencies cooperated. Dr. William Y. Sayad was in charge of the program and Dr. R. O. Cooley, president of the Rotary Club, was the presiding officer.

* * *

Dr. H. Mason Smith, Tampa, was a guest speaker at a meeting held in the High School Auditorium, Bartow, recently. His subject was "Mental Hygiene and the Problems of Adolescent Children."

* * *

Dr. W. A. McPhaul, State Health Officer, recently attended the 29th Annual Conference of State and Territorial Health Officers held in Washington, D. C.

Drs. Roy Holmes and Clay Shaw of Miami attended the meeting of the American Urological Society held in Boston recently.

* * *

Dr. C. D. Hoffmann announces the removal of offices from the Autrey Arcade Building to a new office building he has constructed on the corner of East Robinson and Magnolia Avenues, Orlando.

WILLIAM ALLAN CLAXTON

Dr. William Allan Claxton, formerly of Florida, died May 21, 1936, in Oteen, North Carolina.

Dr. Claxton was prominent in public health work in this state for many years, and his influence was widely felt. During the last years of his life, he was especially interested in tuberculosis, and he made valuable contributions to the knowledge of diagnosis and treatment of this disease.

He was born October 3, 1884, in Verona, Ontario, Canada, and was graduated from Queens University Faculty of Medicine, Kingston, Ontario, in 1909. Three years later he became associated with the Florida State Board of Health. In 1914 he was sent to Tallahassee to direct the first laboratory established there, and in 1915 became licensed to practice in this State.

During the World War, Dr. Claxton served as Captain of the Medical Corps in the Canadian Army. He was relieved from active duty shortly before the end of the war because of illness. He returned to the State Board of Health in 1923 to continue his work in the laboratories. Several years later, he was made commissioner of health for the city of Miami.

In October, 1929, he accepted a position as district health officer for the State Board of Health, and some months later assumed the duties of tuberculosis clinician. He served in the latter capacity until his retirement in December, 1934.

The many friends of Dr. Blackburn W. Lowry will regret to learn of the death of his father, Sumter L. Lowry, Sr., at Tampa on May 24 at the age of 75 years.

* * *

Dr. B. A. Burks of Winter Park left recently for a four months' European visit. He will attend clinics in London and Edinburgh and spend some time in France and Switzerland. He plans to return about October 1st.

Dr. J. G. Lyerly of Jacksonville attended the annual meeting of the Harvey Cushing Neurological Society which met at Rochester, Minn., May 15 and 16.

* * *

Dr. Shaler Richardson of Jacksonville attended the annual meeting of the American Ophthalmological Society which was held at Hot Springs, Va., the first week in June.

* * *

Dr. E. J. Melville of St. Petersburg has a story running in "The Travel Bulletin," a monthly magazine published in Tokio, Japan. Doctor Melville and family spent last summer in the Orient but this year will vacation at their home, "Trails End," at Pass-a-Grille.

* * *

Doctors from Mobile, Pensacola, Gulfport and Biloxi met recently to lay plans for a medical organization to be known as the Gulf Coast Clinical Society. Dr. William Meeker of Mobile was named chairman and Dr. M. A. Lischkoff of Pensacola, secretary. Members of the committee to draw up a constitution and by-laws include: Drs. J. H. Dodson, Mobile; H. L. Bryans, Pensacola, Riley Burnett, Biloxi and Saul LeBaron, Gulfport. The society will meet next October in Mobile.

* * *

Dr. H. Marshall Taylor of Jacksonville attended the annual convention of the American Bronchoscopic Society held in Detroit the last week in May. Doctor Taylor has been president of this society during the past year and, at the meeting in Detroit, delivered his presidential address. The American Bronchoscopic Society was founded in 1917 and Doctor Taylor is the first southern doctor elected as president.

* * *

Drs. James L. Estes, Eugene S. Gilmer and Arthur Knauf of Tampa attended the 33rd Annual Meeting of the American Urological Association in Boston, May 18th to 21st.

* * *

Dr. A. E. Drexel, formerly of Palatka, announces the opening of offices at 350 S. Palmetto Avenue, Daytona Beach.

* * *

Dr. J. H. Pound recently resigned as Chief Physician of the Florida State Hospital, effective July 1, 1936. He will take several months' postgraduate work after which he will enter private practice in Florida.

A very happy surprise was experienced in the Medical Association office in Jacksonville recently. Two of our life members called at the office unannounced: Dr. T. S. Anderson of Live Oak and Dr. L. M. Anderson of Lake City. Dr. T. S. Anderson is 78 years old and has practiced medicine for 57 years—4 years in Missouri and 53 years in Florida.

An old book of Florida Medical Association proceedings for 1895 to 1898 was taken down from the shelf and the two Anderson brothers, in going over this old history, added many interesting comments to the information published.

On April 7, 1896, the Florida Medical Association met in Sanford. There were 18 doctors' names published as answering roll call and the first of this list was Dr. T. S. Anderson, whose address at that time was Carrabelle. At this time there seemed to be five sections: medicine, surgery, gynecology, diseases of children and hygiene. Dr. Anderson in 1896 was chairman of the section on diseases of children. At this meeting in Sanford, he was also elected delegate to the A.M.A.

One previous reference is made to Doctor T. S. Anderson in the old records of the Association. In the treasurer's report for the meeting held in Tampa, March 21, 1894, he is shown as having paid his annual dues of $3.00.

On April 3, 1895, in Live Oak, the medical society of the Third Judicial Circuit of Florida held a meeting at which time Dr. L. M. Anderson invited the society to hold its next meeting at White Springs. At the annual meeting of the Florida Medical Association held in Palatka, April 21, 1897, the names of thirteen doctors were proposed for membership. The proceedings of this meeting state that these doctors "having duly qualified and complied with the terms of the constitution are recommended for admission." Dr. L. M. Anderson, whose address was then Jasper, was included in this list.

At the meeting in Palatka, held in 1897, the name of another of our life members appears: Dr. J. Harris Pierpont of Pensacola. He was the chairman of the committee on legislation and his committee report is published in this old volume. The report includes a number of recommendations, one of which was an endorsement to the State to establish a bureau of public health. An older record shows that Doctor Pierpont was named by the president as chairman of the com-

mittee on legislation at the annual meeting held April 16, 1895, at Gainesville.

One old volume containing the proceedings of 1886 and 1888 is on file in the Association's library. The next volume of proceedings is for 1895-6-7-8. If any member has access to the missing publications of 1889 to 1894, inclusive, it would be a generous move to have these missing numbers placed in the State Association's library. The records are also missing from 1898 to 1902. There is an old volume on file for 1902-3-4-5. In this volume the chief subject is of the transactions of the annual meeting of the Florida Medical Association held April 9, 10 and 11, 1904 at Tampa. At this meeting, 49 members were in attendance. The name of Dr. R. H. McGinnis of Jacksonville among those registered shows that he was in attendance at this meeting. Seventeen new members were elected to membership at this meeting. Dr. R. H. McGinnis is another of the duly elected life members of the Florida Medical Association.

* * *

Dr. Shaler Richardson of Jacksonville read a paper before the Escambia County Medical Society on April 14. The meeting was well attended and a great many of those present entered into the discussion of this paper. Dr. Herbert Bryans, then the president of the Florida Medical Association, entertained, at a hotel dinner, Doctors Richardson, Stewart Thompson, business manager, the local doctors who held appointments on state committees, as well as the officers of the Escambia County Medical Society. Doctor Bryans and the other members of the Escambia County Society entertained their guests royally.

* * *

Dr. H. Hamilton Cooke of Miami delivered four lectures on "Neurosurgery" to the Junior class of the Medical College University of Georgia, Augusta, Ga., the latter part of May. He also read a paper on "The Diagnosis and Treatment of Traumatic Injuries to the Brain" before the Richmond County Medical Society on May 24.

ERRATA

In the May Journal, page 544, under the caption "Our President," Doctor O. O. Feaster was shown as a member of the American Board of Radiology, which was an error. Doctor Feaster was not responsible for the statement. He is a Diplomate in Radiology.

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COMPONENT COUNTY SOCIETIES

DUVAL COUNTY MEDICAL SOCIETY

At the meeting of the Duval County Medical Society held June 2 at the Mayflower Hotel, Dr. Thomas M. Palmer presented a paper on "Congenital Bone Syphilis." Reports of committees were read and miscellaneous business transacted after which refreshments were served.

LAKE COUNTY MEDICAL SOCIETY

The Lake County Medical Society has been instrumental in bringing into being the Allied Professional Health Council of Lake County. Dr. W. L. Ashton, secretary of this new organization writes: "I might add that we have experienced no difficulties through securing the fullest cooperation from the dentists and druggists of this county although there was no county unit of their state associations locally. Also, that the tentative Health Council resulted in the organization of the nurses of the county, numbering forty, into a strong unit of the State Nurses Association."

ORANGE COUNTY MEDICAL SOCIETY

THE ORANGE COUNTY MEDICAL SOCIETY IS NOW 100% PAID FOR 1936. A GREAT DEAL OF CREDIT FOR THIS SPLENDID ACHIEVEMENT SHOULD GO TO THE OFFICERS OF THE SOCIETY: WILLIAM E. SINCLAIR, PRESIDENT; F. H. HARMS, VICE-PRESIDENT; J. A. PINES, SECRETARY, AND SPENCER A. FOLSOM, TREASURER.

PINELLAS COUNTY MEDICAL SOCIETY

A semi-monthly dinner meeting was held by the Pinellas County Medical Society, Friday, May 15 at the Shrine Club. The principal speaker was Dr. O. N. Nelson who presented "Head Injuries." The discussion to this paper was opened by Drs. B. L. Wright and W. P. Moore.

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Mrs. E. W. Veal, Historian . . . . . *South Jacksonville*
Mrs. L. C. Ingram, Parliamentarian . . . . . *Orlando*

COMMITTEE CHAIRMEN

Mrs. Wilburn Lassiter, Press and Publicity . . . . *Gainesville*

Pinellas County Auxiliary

The annual meeting of the Auxiliary to the Pinellas County Medical Society was held at the home of Mrs. Raymond K. O'Brien on April 24th, 1936. Election of officers resulted as follows:

President—Mrs. Franklin W. Roush.
Vice-President—Mrs. O. O. Feaster.
Secretary—Mrs. J. A. Strickland.
Cor. Secretary—Mrs. A. S. Anderson.
Treasurer—Mrs. Prescott LeBreton.

Mrs. Feaster and Mrs. LeBreton were chosen as delegates to attend the 63rd annual convention of the Florida Society to be held aboard the S. S. Florida on April 27, 28 and 29.

Other members of the Auxiliary who are planning to attend were: Mrs. A. S. Anderson, Mrs. Francis Langley and Mrs. Wyman W. Harden, State Auxiliary President. Reports of all chairmen were read and a very successful year came to a close.

Agnes M. Wylie,
Publicity Chairman.

Alachua County Auxiliary

Election of officers was held in March at the monthly meeting held at the home of Mrs. J. Maxey Dell, Jr.:

President—Mrs. E. H. Andrews.
Vice-President—Mrs. Wilburn Lassiter.
President-Elect—Mrs. H. M. Merchant.
Secretary—Mrs. C. F. Ahmann.
Treasurer—Mrs. J. Maxey Dell, Jr.
Chairman—Hygeia—Mrs. G. C. Tillman.
Chairman Publicity—Mrs. J. H. Hodges.
Chairmen Social — Mrs. J. H. Hodges, Mrs. G. C. Tillman and Mrs. D. T. Smith.
Scrap Book—Mrs. J. Lee Summerlin.

The April meeting was held at the home of Mrs. H. M. Merchant at which time plans were made for the Benefit Bridge and Tea to be given at Hotel Thomas for the benefit of the Tornado Fund and the Junior Welfare League who are serving luncheon to the under-nourished children at the Grammar School.

"Red Cross Tornado Fund and Junior League Benefit from Bridge and Tea.

"The Spanish Court of Hotel Thomas furnished a delightful setting Tuesday afternoon for the benefit party sponsored by the ladies of the Medical Auxiliary for the Red Cross tornado fund and Junior Welfare League work.

"Spring flowers added their beauty to the lovely court. A lace covered table with flowers and tall yellow candles from which cakes were served and on each side a punch table, were placed at one end of the court. Near the entrance was a table on which was displayed the prizes, all very attractive and useful, donated by public spirited merchants.

"Mrs. E. H. Andrews, president, assisted Mrs. W. Lassiter, Mrs. J. E. Maines, Mrs. J. M. Dell, Jr., Mrs. C. F. Ahmann, Mrs. J. H. Hodges, Mrs. T. A. Snow, Mrs. W. C. Thomas, and Mrs. Harry M. Merchant in caring for the guests.

"As scores were being checked refreshments were served by the ladies assisted by Olive Dell, Claire Tillman, and Ann Crago. Mrs. Lassiter announced the scores, causing a great deal of interest as each one advanced to the table to select her prize. Tea guests cut for prizes and were welcomed by Mrs. W. C. Thomas."

Mrs. Wilburn Lassiter was hostess Friday evening, May 15th, entertaining the ladies of the County Medical Auxiliary at the regular monthly dinner meeting. Following the dinner a business session was held at which time reports were given of the State Convention. Attending the convention were Mrs. E. H. Andrews, President, Mrs. J. E. Maines, Jr., Mrs. J. Lee Summerlin. Later in the evening the ladies were joined by their husbands for a game of Contract.

National Hospital Day was observed at the Alachua County Hospital and the ladies of the Auxiliary assisted in caring for the guests—serving from 3-5 and 7-9 P. M.

Mrs. Wilburn Lassiter.

ADVERTISERS' NOTES

THE SUMMER-TIME USE OF MEAD'S OLEUM PERCOMORPHUM

During the hot weather, when fat tolerance is lowest, many physicians have found it a successful practice to transfer cod liver oil patients to Mead's Oleum Percomorphum.

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indicate the reasonableness of the above suggestion: (1) In prematures, to whom cod liver oil cannot be given in sufficient dosage without serious digestive upset, Mead's Oleum Percomorphum is the antiricketic agent of choice. (2) In Florida, Arizona and New Mexico, where an unusually high percentage of sunshine prevails at all seasons, Mead's Oleum Percomorphum continues increasingly in demand, as physicians realize that sunshine alone does not always prevent or cure rickets.

Mead Johnson & Company, Evansville, Indiana, invite you to send for samples of Mead's Oleum Percomorphum for clinical use during the summer months to replace cod liver oil.

EMERGENCY TREATMENT OF WOUNDS

When an individual is wounded, two things that demand prompt attention are pain and the danger of infection. If at that time one could apply locally a preparation that is both anesthetic and antiseptic, these needs would be met. It is desirable that the local anesthetic and the antiseptic both be incorporated in the same vehicle because the contaminated tissue is likely to be included in the painful area. It is also desirable that the vehicle be water-soluble so that it may be washed away easily in case the surgeon desires to use some other local application which might be incompatible. For this purpose a water-soluble jelly would seem preferable to an ointment base.

"Metycaine" (Gamma-(2-methyl-piperidino)-propyl Benzoate Hydrochloride, Lilly) is stated to belong to the group of substituted piperidinoalkyl benzoates prepared by Dr. S. M. McElvain. Its anesthetic effects are obtained, according to Eli Lilly and Company, either by infiltration or by topical application to mucous surfaces. In painful ulcerations of the skin and in some open wounds, the pain may be locally controlled by it, thus reducing or avoiding the use of systemically effective analgesics.

"Merthiolate" (Sodium Ethyl Mercuri Thiosalicylate, Lilly) is claimed by these manufacturers to be a superior germicide, which is distinctive for its tissue compatibility.

The problem of supplying both of these agents in a suitable water-soluble jelly was solved, according to report, in the Lilly Research Laboratories. A preparation of this sort might well be a part of the first-aid kit of the ambulance, the hospital, and the physician.

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Brevard	I. F. Bean, M.D., Melbourne	Bob Schlernitzauer, M.D., Rockledge	2nd Tuesday	Varies	3	30%
Broward	Elliott M. Hendricks, M.D., 314 Sweet Building, Fort Lauderdale	R. E. Blount, M.D., 360 S. E. 26th Ave., Fort Lauderdale	Last Wednesday 8:00 P.M.	Elks' Hall, Fort Lauderdale	24	100%
Columbia	L. M. Anderson, M.D., Box 707 Lake City	T. H. Bates, M.D., Blanche Hotel Annex Lake City	1st Monday 7:30 P.M.	Blanche Hotel Lake City	9	90%
Dade	John E. Hall, M.D., Box 2722, Miami	M. E. Tbrelkeld, M.D., Congress Bldg., Miami	1st Friday 8:30 P.M.	Elks' Club Miami	191	86%
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Duval	W. M. Shaw, M.D., St. James Bldg., Jacksonville	H. W. Porter, M.D., St James Bldg., Jacksonville	1st Tuesday 8:15 P.M.	Mayflower Hotel Jacksonville	119	90%
Escambia	A. M. Ames, M.D. Blount Bldg. Pensacola	J. M. Hoffman, M.D., 6 W. Chase St., Pensacola	2nd Tuesday 8:00 P.M.	Board of Health Building, Pensacola	22	88%
Hillsborough	William C. Blake, M.D., 412 Citizens Bank Bldg. Tampa	James S. Grable, M.D., 822 Citizens Bank Bldg. Tampa	1st Tuesday 8:00 P.M.	Tampa Municipal Hospital Tampa	101	93%
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